

Patient and Physician Accounts of Antidepressant Requests in Primary Care

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Abstract

Depression is a nebulous term that is used in a variety of ways to account for a range of experiences usually characterized by low mood, lethargy, diminished pleasure from activities, among others. One prevalent way of making sense of depression in North America is through a biomedical discourse that constructs depression as resulting from an imbalance of neurotransmitters in the brain. Such an explanatory discourse supports antidepressants as the treatment of choice for depression, despite controversy associated with this discourse and disputes about the effectiveness and appropriateness of antidepressants for the treatment of most presentations of depression. In spite of challenges Western physicians face in diagnosing and treating depression, its management overwhelmingly occurs in primary care. Models of primary care treatment decision-making range from those that frame physicians as the principal decision maker (paternalism) to those that feature patients as more autonomous deciders (patient-directed approaches). Existing in the centre of the treatment continuum is a range of joint approaches that feature a more equal relationship between physician and patient.

Over the last several decades, paternalism as the traditional approach to treatment decision-making has given way to joint approaches that are heralded as the best ways to manage complex disorders that involve multiple treatment approaches with variable risks and benefits, as depression is often framed. Requests for antidepressants can be considered either patient-directed or joint approach actions, depending on how they are presented. Research on this topic typically focuses on statistical analyses of whether or not patient requests for antidepressants are granted, and whether they help or hinder treatment. Little research has focused on qualitative explorations of how patients and physicians construct accounts about requests themselves.

For Study 1, Dr. McMullen and I interviewed 11 family physicians and asked them whether they experienced, and how they managed, patient requests for antidepressants. I used a

discursive analytic approach in analyzing the data from the interviews and argue that (a) physicians framed patients as autonomous treatment decision-makers while defining limits on these decisions, and (b) they framed denials of what they characterized as inappropriate requests for antidepressants through patient-centered (and persuasive) approaches to refusal. For Study 2, I interviewed 11 patients about their experiences requesting antidepressants from their physicians. Using a discursive analytic approach, I argue that (a) patients provided accounts of employing what can be considered a soft sell approach in requesting antidepressants, while framing their physician's contribution to decision-making as necessary and important, and that (b) unexpected outcomes which followed requests for antidepressants (i.e., not having their request endorsed by their physician or having their request fulfilled too readily by their physician) can be understood as discrepancies between the patients' preferred level of involvement in the process of decision-making and what they encountered.

The results of Studies 1 and 2 suggest that these interviewees enacted a physician+ joint approach to treatment decision-making by constructing accounts of requests for antidepressants in ways that largely favour the physician as the lead role within a broadly joint approach to decision-making. Despite attempts to avoid conceptualizations of being overly directive or uninvolved in the process of decision-making, physician and patient interviewees framed conflict as inevitable and offer hints as to how conflict might be avoided or mitigated. To the extent that both patients and physicians are attempting to get their respective needs met from one another within the primary care consultation, I frame their accounts as evidence of a mutual or reciprocal persuasion that is characteristic of more equal relationships. Finally, I bring together some of the controversies associated with treating depression with antidepressants in a primary care setting and raise broader questions about the role of the general practitioner in the management of depression.

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Introduction

In this general introduction I explore the broad topics of depression, antidepressants, and primary care. First, I present several past and present discourses that are used to account for and explain depression. Next I examine the trajectory of the creation of antidepressant medications from humble and serendipitous beginnings to their current status as amongst the most popular (and controversial) medications available. I then turn to an exploration of primary care Western medicine, where depression diagnosis and treatment overwhelmingly takes place. In this section I discuss some of the challenges faced by family physicians prior to presenting a variety of treatment decision-making models that have been documented in the literature. I organize these models as three broad approaches: paternalism, patient-directed approaches, and joint approaches. In the final section, I focus on how the shift from paternalism to joint approaches in primary care has allowed a shift in the availability of persuasive actions outside and within the patient – physician relationship, including direct to consumer pharmaceutical advertising (DTCPA) and patient requests for clinical services, with a particular focus on antidepressants.

The purpose of this research is to explore patients' requests for antidepressant medication and physicians' responses to these requests. As such, the literature review is focused on examining prominent medical explanations, treatments, and approaches to managing depression. Throughout this introduction I endeavor to provide a critical perspective on many of the taken-for-granted notions of depression, antidepressants, and primary care management of depression. In doing so I aim to challenge some of the typical assumptions about depression and its treatment that are frequently presupposed and accepted and that contribute toward more limited understandings of this construct.

Depression

“Melancholy is both a normal disposition and a sign of mental disturbance; it is both a feeling and a way of behaving. It is a nebulous mood but also a set of self-accusing beliefs” (Radden, 2000, p. IX).

The notion of depression is as fascinating as it is enigmatic. An extremely conflated term, depression can be used to define both a fleeting sentiment or a defeating and debilitating frame of mind. The term is at once conjured colloquially (“that story was depressing”) while at the same time employed as a psychiatric diagnosis that carries the potential for enormous consequences. Low mood, difficulty with decision-making and concentration, and decreased capacity for work and hobbies quickly come to mind as hallmark signifiers of depression. The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), commonly referred to as the bible of modern psychiatry, provides a medically sanctioned definition of depression that is used more or less strictly by psychiatrists, family physicians, psychologists, social workers, and other mental health professionals.

The DSM-5 classifies a Major Depressive Episode as a mood disorder that is diagnosable when at least 5 of the following 9 symptoms occur over the same two week period nearly every day (one of which must be of the first two listed): depressed mood, markedly diminished pleasure in almost all activities, significant weight loss (or weight gain), insomnia (or hypersomnia), psychomotor agitation (or retardation), fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished ability to think, concentrate, or make decisions, and recurrent thoughts of suicide and/or death. More than 100 different criterion permutations can lead toward a diagnosis of depression, which contributes toward the conflation of the term depression.

Despite the range of symptom combinations, laypeople are generally aware of, and consistent in, their understanding of how depression presents itself in other people (Räty, Ikonen, & Honkalampi, 2006). Conversely, family physicians, who are frequently a first point of contact in the medical system for patients with depression, have widely different conceptions about what constitutes depression and a poor record of recognizing depression in their clinical practice (Andersson, Troein, & Lindberg, 2001; Cepoiu et al., 2007). As the opening quotation suggests, depression's puzzling landscape is perhaps explained by the broad range of symptoms, experiences, and expectations that have been generated and shaped over the long history of this interesting construct. Not surprisingly, the range of experiences that constitute depression create challenges in exploring the extent to which people in the general public are currently understood to be depressed and what being labeled 'depressed' actually means.

Depression prevalence. Depression is often referred to as the 'common cold' of mental illness (Kline, 1974). The implication that depression is routinely experienced is unmistakable and, by all accounts, this metaphor appears apt. For instance, researchers routinely cite the World Health Organization's assertion that depression is a leading contributor to the *global burden of disease* (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). The most often cited Canadian prevalence statistics for depression come from a collection of studies completed in different Canadian provinces in the late 1980s and early 1990s. They are commonly known as the Sterling County Study (Murphy, Laird, Monson, Sobol, & Leighton, 2000; Murphy, Monson, Laird, Sobol, & Leighton, 2000), the Edmonton Epidemiological Survey (Bland, Newman, & Orn, 1988; Bland, Orn, & Newman, 1988), and the Ontario Mental Health Supplement (Parikh, Wasylenki, Goering, & Wong, 1996). The results of these three major Canadian epidemiological initiatives have been frequently combined to form low and high estimates of depression across Canada. These studies suggest that the lifetime prevalence of depression in Canada is between

7.9% and 8.6% and estimates of 1-year prevalence rates are between 4.2% and 4.6%. A more recent Canadian epidemiological study found slightly lower 1-year prevalence rates (4.0%) but higher lifetime prevalence results (10.8%; Patten et al., 2006). These surveys suggest that depression is indeed common.

While these studies do provide a range of relatively consistent estimates, it is important to consider potential challenges that face this body of research. For instance, only households were contacted for participant recruitment; consequently, people living in health care institutions, on reserve, in prisons, and in extremely remote locations were typically not sampled. While these places comprise a very small portion of the overall population of Canada and its communities, experiences of depression may well be overrepresented in these locations. Other critiques that have been leveled against this type of research include the transitory nature and experience of depressive symptoms, the differing instruments used to classify disorders, the high comorbidity rates of mental illness diagnoses, and a high level of recall bias with regard to participants recounting their lifetime prevalence of depression (Patten, 2003; Waraich, Goldner, Somers, & Hsu, 2004). Of course, it must also be noted that the cutoff scores for questionnaires used to determine whether a participant in epidemiological research meets the study's criteria of having or not having the disease or illness are arbitrarily chosen. It is difficult to say how these issues might influence the prevalence data, though it is clear that our estimates are only that. Furthermore, fulfillment of diagnostic criteria tells us nothing about a given populations' experience of depression, the severity of symptoms or the impact of those symptoms on daily life.

Prevalence data are typically cited in order to situate depression as a serious illness and to provide a justification of (and rationale for) the study of depression in comparison to other diseases. While the data generally suggest that depression is very common, they stand on

contested ground. These prevalence statistics are built upon certain assumptions about the construct of depression. For instance, depression is assumed to be a distinct and measurable construct that occurs as an isolated event for some individuals and not others. As well, the very exercise of determining prevalence through epidemiological research contributes toward a particular construction of depression as a disease entity (as opposed to a social one, for example). When unpacked, the specificity and precision of our knowledge comes into question. Essentially, it becomes difficult to say just how common this particular cold is.

Historical explanatory discourses for depression. The prevalence data frame depression as a common North American medical disorder and there is little doubt that this discourse is a dominant way in which depression is presently framed. Prior to exploring this current and prevailing discourse, it is important to consider previous ways of understanding and constructing depression, some of which date back hundreds of years. What follows are several explanatory discourses for depression that were traditionally available to people. Under the heading *Depression as disorder* I provide a brief account of the historical construct of depression that can be considered the predecessor of a more modern discourse of medicalized depression. *Depression as weakness of faith* and *the brilliant melancholic* are titles used to depict two less common explanatory discourses of depression that were previously available and provide an interesting contrast to the medicalized discourse of *depression as disorder*.

Depression as disorder. The concept of depression is one of the most longstanding of the currently classified mental disorders. Melancholia, as it was traditionally known, was associated with sadness, aversion to food, sleeplessness, irritability, and restlessness at least as early as the Hippocratic writings of the fifth century BCE (Jackson, 1986). While Hippocrates is often credited with the first reference to melancholia as a mental disorder, lay descriptions are said to appear as far back as ancient Egyptian times (Davison, 2006). The causal explanation for

melancholia in Hippocratic times was disequilibrium of the four bodily humours of blood, phlegm, yellow bile, and black bile. Each was associated with a certain body part, season, and temperament. An excess of black bile (the literal English translation of the Greek terms, *melas khole*) originating from the spleen was assumed to cause melancholia (Radden, 2000). Black bile was associated with the earth, the autumn season, and cold and dry qualities (Jackson, 1986). Variations on this humoral theory were drawn upon to explain melancholia until the sixteenth and seventeenth centuries.

Toward the end of the seventeenth century and into the eighteenth century, a mechanical understanding of melancholia began to replace the humoral one. Jackson (1986) provided an account of how Descartes, Newton, and others helped to shift the broad conceptualization of many biological phenomena toward mechanical explanations. The body was viewed as a series of interacting components and canals that circulated blood throughout the extremities via mechanical principles. At this time, melancholia was seen as a thickening and pooling of the blood; essentially a problem of circulation. The nineteenth century marked the slow replacement of the term ‘melancholia’ with ‘depression,’ first in relation to the symptoms and then to define the illness itself. The nineteenth and twentieth centuries were dominated by the clinical-anatomical view of disease, where discrete anatomical lesions were correlated with illness. This view allowed the ideas of mental ‘neuroses’ to expand and led to increasingly popular bio-psycho-social explanations for depression and other burgeoning mental disorders classified at this time (Berrios, 1988).

This description is an extremely cursory history of depression; my intention is not to provide a thorough account. Such a description does, however, mirror the typical ‘nod’ many writers give to the historical development of depression. The brief description I have provided, and those of many others, are essentially historical descriptions of *medicalized* depression. While

medicine was much closer to philosophy in Hippocrates's time than it is now, the humoral theory and the thick blood hypothesis provide discrete physical explanations for, and causes of, depression. It is perhaps not particularly surprising that present-day accounts of past events might reflect the more popular discourse(s) of our contemporary times; in this case, those describing a biomedical explanation.

Rousseau (2000) argued that a truly comprehensive history of depression is a near impossible undertaking given how wide and deep the story of depression goes. He said, "[It] would require, as a minimum, the historian's utmost vigilance to nuance, difference, and the inclusion of non-medical literature, especially poetry, drama, and non-didactic prose" (p. 71). Here, the author acknowledged the existence and importance of 'non-medical' discourses in an inclusive history of depression. Consequently, I briefly explore two popular discourses of depression that were historically available to people: *depression as weakness of faith* and *the brilliant melancholic*.

Depression as weakness of faith. For centuries, people have drawn upon religious discourses to explain and understand depression. Various explanations that have been documented include that God has afflicted a person with a dejected state (or allowed him or her to be afflicted) as a punishment for sin or weakness of faith, as a means to repent for sins, or in order to test a righteous person (Jackson, 1986). Such explanations likely did not represent the dominant discourse of a specific era, but rather existed alongside the humoral explanations of Hippocrates and his contemporaries across many hundreds of years. There is also the notion of 'acedia.' In the fourth century, the Christian church developed this deadly sin (more commonly referred to as sloth) that came to mean laziness, apathy, and a type of numbness and lack of feeling that led one to neglect one's faith (Davison, 2006). Kroll and Bachrach (1984) argued that such religious explanations were drawn upon in only a very distinct minority of cases. While

God was understood to be the ultimate cause of dejected states in these cases, He was still seen as working through more mundane and immediate processes, such as those accounted for by humoral theory (Jackson, 1986). Thousands of years ago, a person could have understood his or her melancholia through religious discourse, but might well have sought the help of a healer in order to re-balance the humours. Still today, some people draw upon religious explanations for mental illness, and look to the power of faith for relief (Corrigan, McCorkle, Schell, & Kidder, 2003). Religious understandings have likely existed for as long as melancholia has been described and have been intertwined with other relevant discourses of the day.

The brilliant melancholic. Originally defined by Aristotle and his followers, the melancholic temperament was popularized during the Renaissance (Radden, 1987). In this case, a melancholic temperament refers to an attribute a normal person might have. It is a way of looking at the world rather than a disease state. Here, the disease of melancholia was seen as separate yet related to the melancholic disposition. For example, while the melancholic temperament was still marked by sadness, dejection, and apathy, it was also seen as the “wellspring from which came great wit, poetic creations, deep religious insights, meaningful prophecies, and profound philosophical considerations” (Jackson, 1986, p. 99). This temperament was seen as caused by black bile, celestial events (e.g., being born under the planet Saturn), and engagement in intellectual pursuits (Radden, 2000). While it was ultimately treated as something quite different from the disease state of melancholia, some of the same causes were drawn upon to explain it. Perhaps most interestingly, those with the melancholic disposition were respected, revered, and emulated during Elizabethan times, a stark contrast to how melancholia and depression are traditionally viewed by others.

This brief account of medicalized discourses, as well as the introductions to religious and melancholic temperament discourses, represent the typical story told about depression and two

less common discourses that were historically available. These brief examples show that by using various discourses, the same phenomenon can be understood in very different ways. The discourses that were available in past eras provide an interesting basis for, and fascinating connection to, some currently available ways of talking about depression.

Current explanatory discourses for depression. Modern discourses used to explain and construct depression developed in much the same way that more historical discourses did – in the social and cultural context of their respective eras. *Depression as internal conflict* is a notion constructed out of Freud’s psychoanalytic tradition and might be considered an offshoot of a *depression as disorder* discourse, in the same way that psychoanalysis was an outgrowth of medicine. *Depression as a socio-economic matter* depicts a more macro view of depression and frames this construct as existing beyond the individual, while *depression as identity* represents a focus on individual personality factors. *Depression as mystery* recognizes the unknowable quality of depression that some describe. Finally, *depression as medical disorder*, a highly conspicuous discourse, provides a continuation from the historical *depression as disorder* discourse that was previously explored.

Depression as internal conflict. This discourse refers to the concept of internal conflict very broadly, as an unresolved mental struggle. This notion was originally proposed by Sigmund Freud, who likened the concepts of both mourning and melancholia to a reaction to a literal or figuratively lost object (e.g., a person). Freud (1917) argued that in the case of mourning, attachment becomes withdrawn from the lost object and eventually reattached to a new object, while in the case of melancholia, the attachment becomes detached from the lost object and withdraws into the reality-focused ‘ego.’ Freud argued that a conflict then occurs between the ego and the lost object, which results in symptoms of melancholia which are largely comparable to symptoms argued to be associated with mourning (including “painful dejection, cessation of

interest in the outside world, loss of capacity to love, inhibition of all activity”; 1917, p. 244) with the addition of a diminished self-regard and impoverishment of ego. Though Freud’s notions about internal conflict and melancholia could well be relegated to the previous introductory section, the concept of depression as internal conflict has been widely taken up in the years since he first proposed this notion.

Research conducted more than 25 years ago correlated participant reports of depressed mood with their evaluation of their self-concept. The results suggested that conflict between ‘actual self’ and ‘ideal self’ were related to higher rates of dejection-related emotions and symptoms (Higgins, Klein, & Strauman, 1985). More recent research comparing depressed adults with non-depressed adults has shown that depression-related distractor words (e.g., ‘sad,’ ‘hopeless’) can induce significant emotional conflict in the depressed sample but not the non-depressed sample, suggesting that depressed individuals ruminate on negative and conflicted emotions and that internal conflict is, in some way, at the core of depression (Hu, Liu, Weng, & Nortoff, 2012). An important question that remains unanswered from this perspective is whether internal conflict drives or results from depression. In any case, the concept of internal conflict remains an important way to understand depression.

Depression as a socio-economic matter. Current talk about depression is frequently drawn from what can be considered a socio-economic discourse. The basic argument is that environmental (i.e., external) forces, usually couched in terms of adversity, stress, or suffering, impact upon a person to the extent that he or she experiences depression. Put more simply, depression is caused by bad things that happen. While there are many theories that purport to explain how stressful life events lead to depression (the diathesis-stress model, for instance, which postulates that depression and other mental illnesses can be explained through the relation

between an individual's personal resiliency and negative life events), the focus here is on external factors that contribute to depression.

This link is continuing to be explored today and, indeed, research programs have been built upon the study of negative life events on mental health, as well as the potential mediating and moderating effects of the severity of the event, one's level of perceived support, and personal qualities such as resilience and coping ability. As one example, using a rare longitudinal design, researchers found that increases in adverse life events (e.g., financial strain, deprivation, and poverty) led to an increased risk of depressive symptoms seven years later (Lorant et al., 2007). Laypersons' understandings of depression often draw upon such environmental explanations (Goldstein & Rosselli, 2003; Lewis, 1995).

One can hardly explore the link between adverse life events and depression without considering those who are most likely to experience challenging circumstances. For instance, certain minority groups have lower health status (Cooper, 2004), education levels, and income (Smith, Hatcher-Ross, Wertheimer, & Kahn, 2005) relative to the majority population in North America. The commonly held notion that women are twice as likely as men to experience depression also comes to mind when one considers the long-standing evidence that suggests women face increased psychological distress (Kessler & McLeod, 1984). This distress has been associated with the "cost of caring" – the notion that the caring role women traditionally take up in the family often occurs in addition to expectations related to paid employment, limited time and resources, and personal needs. For instance, mothers are more likely to be unemployed or employed in lower paying 'pink collar' work than women without children (Budig & England, 2001). As well, women with or without children are more likely than men to be victims of violence and sexual abuse (Koss et al., 1994). There is evidence that women in particular understand and explain their depression in the context of these adverse and challenging social

events (i.e., in many cases what constitutes their ‘everyday lives’) by drawing on related discourses of ‘femininity’ and ‘the good woman’ (Lafrance & Stoppard, 2006; Stoppard, Thomas-MacLean, Miedema, & Tatemichi, 2008). Negative external events have long been implicated with depression and represent an important available discourse.

Depression as identity. Another relevant discourse constructs depression as being within a person and tied closely to personality, character, and identity. Here, depression is discussed in terms of disposition and temperament, though it is not routinely associated with the genius, creativity, and respect of *the brilliant melancholic*. Cheever (2000) presented Elizabeth Wurtzel’s personal account of depression in this way. Wurtzel is depicted not as *having* depression, but *being* depressed. For her, depression is fundamental to her sense of self. Taking medication does not allow her to return to normality or to become her ‘old self’ but instead represents an alteration of true self. Similarly, in focus group research with adolescents, Wisdom and Green (2004) found that a number of participants explained their depression through identity, and though they still used antidepressant medication, they did not tend to show improvement. The return to normalcy versus alteration of self is evidently a common struggle for people with depression (Garfield, Smith, & Francis, 2003). While the discourse of ‘depression as identity’ does not necessarily have pejorative connotations, research has suggested that a high percentage of Canadian laypeople draw on uncomplimentary identity explanations (i.e., weakness of character) to explain depression in others (Wang et al., 2007).

Depression as mystery. Another construction of depression worth considering is depression as mysterious, dark, irrational and unknowable. In some cases this discourse appears to function as a refutation of other explanatory discourses and was perhaps born out of historically available discourses associated with religious faith and the divine. Those who take up this discourse are perhaps unable to fully construct a reasonable source or explanation for their

depression. There are an abundance of depression narratives that leave their tellers confused and mystified. Such accounts are occasionally constructed in the context of a normal or even ‘perfect’ life that is torn by depression. This story line is evident in the popularized depression narratives of William Styron, Andrew Solomon, and Jeffery Smith. Stern (2003) suggested that these three authors tell stories that are ultimately those of mystery. She states, “the writers describe depression at various times as impenetrable, elusive, unfathomable, unknowable, and inexorable” (p. 94). Lewis (1995) provided an account of how research participants drew on typical explanatory processes for their depression (e.g., environment, social circumstances, biological), but were ultimately left with an inability to fully explain or rationalize it. The search for meaning and understanding is common in those who experience depression, and for many people there will always be an element of their experience that remains incomprehensible.

Depression as biomedical dysfunction. The final discourse that will be presented, a biomedical view of depression, currently dominates the public discourse in Western society and is routinely taken up by physicians, researchers, journalists, and laypeople alike. Advocates of this perspective argue that a physical disorder results in a certain pattern of discrete symptoms, which are said to be manifestations of biological dysfunction. The most common biological explanation for depression, and one that will be delineated in more detail in the following section, is an imbalance in neurotransmitters, namely serotonin and/or norepinephrine (France, Lysaker, & Robinson, 2007). This explanation underlying the biomedical discourse is clearly quite different from the humoral and mechanical theories proposed hundreds of years ago, though they are strikingly similar in their focus on a depleted organ or body region. The biomedical dysfunction discourse is built on the findings that low levels of neurotransmitters have been reported in some people with depression (See Belmaker & Agam, 2008 for a recent review) and the proposition that most antidepressants work by influencing serotonin and/or

norepinephrine. This hypothesis is referred to in a number of ways, including the ‘monoamine hypothesis,’ the ‘serotonin hypothesis’ or simply, the ‘chemical imbalance’ explanation for depression. These ideas will be discussed in more detail in the following section; however, it is important to note that the serotonin hypothesis goes back to at least the 1960s, when newly developed pharmacological treatments encouraged the possibility of such theories and medications were increasingly viewed as the solution to many mental health problems (Healy, 1997).

A biomedical approach to understanding depression is exceedingly prominent in the media (Blum & Stracuzzi, 2004; Rowe, Tilbury, Rapley, & O’Ferrall, 2003) and is a common explanatory discourse taken up by medical professionals (McPherson & Armstrong, 2009; Thomas-MacLean & Stoppard, 2004) and people experiencing depression alike (France et al., 2007). Lafrance (2007) argues that this biomedical discourse thoroughly dominates the current conversation about depression due to the immense power that science and medicine wield in shaping our view of health and illness in North America. Despite the dominance of the biomedical explanatory discourse, critiques have been leveled against medicalized constructs of depression since they were first presented more than 50 years ago, and many of them centre on the monoamine hypothesis itself (Belmaker et al., 2008). Though this underlying hypothesis is widely accepted, it has been criticized on the grounds that evidence for abnormalities of serotonin and norepinephrine in depressed patients is hardly conclusive (Middleton & Moncrieff, 2011; Moncrieff & Cohen, 2006; Moncrieff & Cohen, 2009). In essence, a diagnosis of depression cannot be made through any manner of biomedical assessment of susceptibility or disease that does not rely almost exclusively on an individual’s account of his or her symptoms. These factors, in addition to controversy regarding the therapeutic effect of antidepressants

(which will be explored in the following section), contrast sharply with the broad acceptance and popularity of the biomedical explanatory discourse of depression.

The purpose of describing past and present discourses is not to suggest that people construct their understanding of depression within tight boundaries, but rather it is to present a multiplicity of perspectives that are available to be drawn upon in order to make sense of depression, its causes, course, and treatment. Indeed, there is substantive overlap in people's conceptualizations of their depression. While the biomedical perspective might occupy the current dominant position of understanding depression in North America, it is not (and never has been) the only discourse that is culturally available to explain depression. As an example, France et al. (2007) asked research participants to spontaneously generate causes of depression. Though the highest proportion of likely causes reflected a chemical imbalance (16.3%), the death of a significant other (14.7%) and stress (12.4%) accounted for similar levels of generated causes. Further, when asked how likely depression was to be caused by certain events, the highest proportion of participant agreement was associated with stressful circumstances (98.1%), difficult childhood experiences (85.5%), and chemical imbalance (84.7%). These data suggest that people have variable (and overlapping) understandings of the likely causes of depression.

Likewise, the taking up of a given explanatory discourse for depression, such as a biomedical dysfunction discourse, does not necessarily imply that a 'consistent' approach to alleviating suffering (e.g., antidepressants) will necessarily be preferred. For instance, there have been countless approaches touted to alleviate depression over the past several decades, each of which correspond to one or more explanatory discourses, including research, therapies, and self-help programs that promote the importance of increasing personal resiliency (Southwick, Vythilingam, & Charney, 2005); improving support networks (Teo, Choi, & Valenstein, 2013); stress management (Marchand, 2012); decreasing internal conflict (Watson, Goldman, &

Greenberg, 2011); activating healthy behaviours that are argued to improve mood (Rethorst & Trivedi, 2013); and challenging negative thinking patterns (Beck, 1995), among other more personal approaches involving faith, duty, and perseverance.

Despite this abundance of non-pharmaceutical approaches to treatment, there is little doubt that antidepressants are the most frequently prescribed treatment for depression in primary care (Robinson, Geske, Prest, & Barnacle, 2005). As the purpose of the present research is to investigate patient and physician accounts of patient requests for antidepressants, it is this treatment that will be further explored. In keeping with the importance that the biomedical dysfunction discourse of depression commands in western society, any discussion thereof would not be complete without a description of the chemical compounds that generated this particular explanatory discourse.

Pharmaceutical Treatments for Depression

While modern psychopharmacology arguably began in the late nineteenth century, the 1950s are frequently considered to be the “golden decade” of psychopharmacology (Curzon, 1990 as cited in López-Muñoz, Alamo, Juckel, & Assion, 2007). It was during this time that various compounds used to manage affective disorders and other mental illnesses were discovered and refined, starting with the antidepressants iproniazid and imipramine in the 1950s and early 1960s (Domino, 1999). Prior to the synthesis of these and other compounds, medications such as barbiturates, amphetamines, and opioids were the primary treatment for depression, but these typically had non-specific effects or were considered adjunct to other biological treatments, including chemical or electrical shock therapies (López-Muñoz & Alamo, 2009).

First-generation antidepressants. In this section, the first drugs that were invented that could be considered and classified as antidepressants will be explored: monoamine oxidase

inhibitors and tricyclic antidepressants.

Iproniazid and the monoamine oxidase inhibitors (MAOIs). Like many pharmaceutical discoveries, the detection of the antidepressant effects of iproniazid (which was assumed to work by inhibiting the monoamine oxidase enzyme causing a slowing of the breakdown of the neurotransmitters norepinephrine and serotonin) occurred serendipitously in the sense that it was originally used as an antimycobacterial agent to treat tuberculosis, but was found to have psychostimulating and mood enhancing side effects (Lieberman, 2003). Within a few years iproniazid and other MAOIs were the most widely used treatment for depression; however, their decline in the early 1960s was as quick as their clinical introduction, as unexpected side effects (including renal toxicity, jaundice, and sometimes fatal hypertensive crises) were, fairly or unfairly, attributed to these drugs (Blackwell, 1963 as cited in López-Muñoz et al., 2007). This quick and total acceptance followed by controversy resulting in eventual rejection of this class of antidepressant drugs would come to be a common thread in the history of antidepressant medication.

Imipramine and the tricyclic antidepressants (TCAs). While iproniazid was being prescribed in great numbers in the mid to late 1950s, imipramine was just starting to be trialed for its antidepressant effects. Imipramine's story begins with phenothiazine, a compound used as a dye for the textile industry in the late nineteenth century (López-Muñoz et al., 2009). Further investigation and molecular modification of phenothiazine 70 years later led to the creation of imipramine (and other similar compounds) that had antihistaminic as well as sedating properties (Domino, 1999). Unlike iproniazid before it, this TCA and its similar compounds (discovered to work by blocking the reuptake of norepinephrine and serotonin neurotransmitters from the brain synapse) were trialed with psychotic patients, as their sedating effects were assumed to be helpful for this population (Healy, 1997). Unexpectedly, imipramine appeared to cause

worsening agitation for those with schizophrenia and other presentations associated with psychosis, though a marked improvement in mood was noted for other patients (Kuhn, 1958 as cited in Lieberman, 2003). Despite its own toxicity risks and unpleasant side effects that became widely known (including constipation, urine retention, blurred vision, sedation, photosensitivity, memory disorders and dizziness), imipramine replaced iproniazid as the most popular antidepressant of the 1960s (López-Muñoz et al., 2009).

López-Muñoz et al. (2007) argued that these initial antidepressants were not just important for the advancement of psychopharmacology or the treatment benefits they offered patients. They further argued that the development of iproniazid and imipramine were important in terms of driving a biological theory, as the effects of these compounds provided the rationale for the monoamine hypothesis, which was the first argument that suggested depression could be understood through a biomedical explanation. In essence, the hypothesis about the role of monoamines in depression followed the development and testing of the treatment (rather than the other way around) and gave way to what is now a central hypothesis at the core of the highly dominant (and controversial) biomedical discourse surrounding depression. López-Muñoz, Assion, Alamo, García-García, and Fangmann (2007) accounted for this shift by arguing that with the development of iproniazid and imipramine, depression ceased to be an illness of the mind and instead became an illness of the brain. As research and development has produced newer antidepressants that are prescribed in greater and greater numbers since these initial offerings, the ‘biomedical dysfunction’ discourse achieved the status of the dominant approach to understanding depression.

Second-generation antidepressants. Following the successes and failures of iproniazid and imipramine, pharmaceutical research intensified in an attempt to minimize the side effects and maximize the efficacy of antidepressant medications. What resulted is a class of

antidepressants that is one of the most commonly prescribed drugs of all time: selective serotonin reuptake inhibitors.

Fluoxetine and the selective serotonin reuptake inhibitors (SSRIs). Unlike the other two classes of antidepressants, fluoxetine and other SSRIs that followed constitute the first psychoactive drugs developed “in line with a procedure of rational and directed design” (López-Muñoz et al., 2009, p. 1576) rather than through serendipity or by accident. Fluoxetine was the first SSRI and was developed in the 1970s through attempts to further isolate reuptake inhibition on the serotonin system alone (an eventual finding that contributed to the monoamine hypothesis), with the goal of reducing side effects argued to be caused by the effects of TCAs across multiple neurotransmitters. Researchers ultimately succeeded, and this new class of antidepressants had fewer toxicity effects and significantly fewer severe side effects than its predecessors (Domino, 1999; Lieberman, 2003).

Fluoxetine (trade name: Prozac) was introduced in the USA in 1987 and the SSRI class of drugs went on to replace TCAs as the treatment of choice for depression. By 1990, Prozac was the most widely prescribed drug by North American psychiatrists, and by 1994 it sold more than any other drug worldwide, with the exception of the indigestion drug Zantac (Shorter, 1997). The unprecedented popularity of Prozac spurred other pharmaceutical companies to develop their own SSRIs, and by the late 1990s there were several alternative options available, including a newer class of medication called serotonin - norepinephrine reuptake inhibitors (SNRIs), which work on both neurotransmitters. SSRIs and SNRIs are similar enough that they are both widely considered to be ‘second-generation’ antidepressants compared to the first-generation MAOIs and TCAs (Spina, Santoro, & D’Arrigo. 2008).

Initially, Prozac and the broader class of SSRIs were argued to work more effectively than their predecessors with few of the risks of toxicity or significant side effects (Lieberman,

2003). It has also been argued to be the drug most written about, with well over 25,000 scientific publications devoted to fluoxetine alone (López-Muñoz et al., 2009). Prozac also made its way into popular Western culture in a way that most pharmaceutical products never do, resulting in a barrage of ‘wonder drug’ cover stories and feature articles in widely read American publications such as Time and Newsweek (Cowley & Holmes, 1994; Lemonick, 1997). Like imipramine before it, SSRIs and SNRIs have all but replaced the previous iterations, though first-generation antidepressants are still occasionally trialed with patients who do not respond to SSRIs or SNRIs, and in severe, unremitting cases of depression (López-Muñoz et al., 2007).

The SSRI and SNRI legacy: From wonder drug to contested treatment. Given the promise of safety and effectiveness of second-generation antidepressants as well as their meteoric rise in popularity, it appeared that the pharmaceutical industry had finally perfected the antidepressant. However, as increasing numbers of patients began using these newer medications, occurrences of troubling side effects and high rates of discontinuation called into question the safety profile and effectiveness of second-generation antidepressants.

Risks and side effects. While SSRIs and SNRIs are arguably much safer with less frequent and less severe side effects than those reported as arising from first-generation antidepressants, these medications are not without their own risks. For instance, ‘serotonin syndrome’ has been reported in individuals taking high doses of SSRIs and may consist of confusion, agitation, autonomic nervous system dysfunction and neuromuscular abnormalities (Lane & Baldwin, 1996). Despite that serotonin syndrome can usually be treated swiftly by discontinuing the SSRI, this side effect can be fatal. Furthermore, 9000 instances of serotonin syndrome that resulted in moderate or serious effects were reported to poison control centres in America in 2005 and the incidences appear to be rising (Ables & Nagubilli, 2010; Birmes, Coppin, Schmitt, & Lauque, 2003). Other potentially serious, albeit rare, side effects include a

lowering of seizure threshold, restless leg syndrome, and other extrapyramidal symptoms (Gumnick & Nemeroff, 2000).

Another rare but very serious side effect involves a paradoxical increase in suicidal risk in those using second-generation antidepressants. While this effect seems completely contrary to what would be expected, clinical research conducted in the early 2000s suggested that children, adolescents, and young adults in particular were at increased statistical risk of suicidal ideation and behaviour compared to those taking placebos (Hammad, Laughren, & Racoosin, 2006; Olfson, Marcus, & Shaffer, 2006). Other arguments suggest that this risk is increased only in the initial weeks after starting an antidepressant treatment regime, and must be balanced against the risk of suicide associated with severe untreated depression (Jick, Kaye, & Jick, 2004). One potential explanation for this potential increased risk of suicide is the claim that antidepressants improve energy levels, reduce apathy, and increase ability to make decisions in those who meet diagnostic criteria for severe depression, perhaps to a degree sufficient enough to allow young people to more seriously entertain the possibility of suicide. Whatever the case, research claims of increased suicide risk resulted in the United States Food and Drug Administration (FDA) and Health Canada requiring ‘black box warnings’ to be included on all antidepressants sold in America and Canada, which are the most serious warnings that can be mandated in prescription drug labeling.

Though few SSRI or SNRI users will experience problems as severe as those presented here, many more report subtler side effects associated with these medications. For instance, sleep disturbance, weight gain, and sexual dysfunction are common effects of modern antidepressants (Ferguson, 2001). And though people commonly endorse beliefs that antidepressant medication will help them, they also report concerns about the long-term effects of taking antidepressants, becoming dependent on them, overuse, and the potential harmfulness of such medications

(Brown et al., 2005). Likewise, researchers have reported that patients taking antidepressant medication have felt at once a return to normalcy due to the decrease in depressive symptoms and at the same time less normal due to the stigma associated with taking antidepressant medication (Garfield et al., 2003).

Efficacy. One can imagine how the possibility of negative side effects of the type presented might be risked or tolerated when the effects of the treatment clearly outweigh the discomfort or difficulties that result from the side effects; however, this compromise is not clearly the case for SSRIs and SNRIs. Though second-generation antidepressants were initially billed as comparable in efficacy to antidepressants that came before them, research has suggested that depression remission rates are lower when treated with SSRIs as compared to TCAs and that approximately 30% of patients experience no therapeutic benefit from antidepressants (Gunnick et al., 2000). As well, the recommended use for SSRI and SNRIs has increasingly narrowed when it comes to the severity of depression that they are recommended to treat. Initially, second-generation antidepressants were the recommended treatment for mild, moderate, or severe depression. In 2004 the National Institute of Health and Clinical Excellence in the UK changed their treatment guidelines to recommend their use only for moderate to severe depression, but not mild depression (Middleton et al., 2011). More recently, it has been suggested that antidepressants are effective only for those with more severe depression (Fournier et al., 2010; Kirsch et al., 2008). and doubts are beginning to surface about whether even these effects are clinically meaningful (Moncrieff et al., 2009). These evolving findings and recommendations certainly suggest that the clinical consensus on the basic utility of antidepressants is in doubt.

There are several possible explanations for the shifting positions regarding antidepressant efficacy. One such explanation involves progress in how the placebo effect is understood as it applies to antidepressants. For instance, the role of the placebo effect has long been recognized

in research trials for new antidepressants, with efficacious medications showing response rates only 25% to 30 % higher than that of placebo (Thase, 1999). This increased efficacy of approximately one-third over placebo is certainly a considerable effect and it is the combination of the known placebo effect and the therapeutic effect that has resulted in strong claims about the helpfulness of antidepressants. However, some aspects of participation in clinical trials that may have contributed to the placebo effect (such as multiple interactions and evaluations from healthcare professionals at various intervals) are not applicable to many patients using antidepressants in their day-to-day lives (Gumnick et al., 2000). The result is that while it may seem inconsequential that the placebo effect is weaker in the ‘real world’ than it was once thought to be, the clinical utility of this medication compared to taking nothing is reduced.

Another influence on changing notions about antidepressant efficacy involves recent analyses of previously unpublished manuscripts. Turner, Matthews, Linardatos, Tell, and Rosenthal (2008) compared the known published literature base on antidepressant efficacy with FDA reviews of all studies of antidepressant agents. They concluded that there was a significant publication bias that resulted in 94% of published articles suggesting findings of positive efficacy compared to only 51% when unpublished manuscripts were included in the analysis. While research of all types suffers from publication biases related to non-significant findings, the ‘file drawer phenomenon’ is of particular relevance for antidepressant effectiveness literature as meta-analytic studies have only recently begun including unpublished pharmaceutical and academic research data. One result of the inclusion of more complete databases is that the placebo effect is now estimated to be greater than 80% of the response rate of antidepressants, and efficacy rates are now estimated to achieve statistical significance only in trials involving the most severely depressed patients (Kirsch et al., 2008; Pigott, Leventhal, Alter, & Boren, 2010).

The final explanation for the shifting positions on antidepressant efficacy I will explore is what Moncrieff and Cohen (2009) portray as the broader medical community's historical reliance on a 'disease centered model' of understanding psychiatric drug action. The underlying assumption here is that medications work to correct underlying biological abnormalities that produce symptoms. This 'disease centered model' has shifted toward an increasingly 'drug centered model' of action that assumes that medication induces "complex, varied, and often unpredictable physical and mental states that patients typically experience as global, rather than distinct" (Moncrieff et al., 2009, p. 1535). This latter view encourages an understanding of depression that is more nuanced and is more likely to encourage consideration of the balance of positive and negative antidepressant effects, as far as the question of efficacy is concerned.

Despite controversies over antidepressant efficacy and treatment guidelines that have shifted recommendations away from antidepressants as a first line of treatment for mild to moderate depression, antidepressants remain the most widely used treatment for depression in primary care and the most frequently prescribed medications in North America (Robinson et al., 2005). In Canada, 5.8% of those aged 15 years of age and older were taking antidepressants in 2002, which, the authors argued, represents a substantial increase compared to 1990 rates (Beck et al., 2005). To this point, recommendations for antidepressant treatment by Canadian physicians have increased by nearly one million prescriptions each year between 2000 and 2004, before reducing slightly in 2005 (Patten, Esposito, & Carter, 2007). However, these estimates of antidepressant use and the considerable year-over-year increases in antidepressant recommendations in Canada seem insignificant in comparison to the rates of use in America. Antidepressant use in the United States among all ages increased nearly 400% between 1988 and 2008 with more than 10% of Americans age 12 and over taking antidepressants between 2005 and 2008 (Pratt, Brody, & Gu, 2011). Possible explanations for the difference between Canadian

and USA rates include higher estimates of depression itself in America (Kessler, Chiu, Demler, & Walters, 2005) and the differing time frames of comparison.

In spite of (or perhaps because of) the high rates of antidepressant prescriptions, many people discontinue these medications. Of those who begin an antidepressant treatment regime, up to 55% of patients will discontinue after three months, and as many as 70% will discontinue after six months (Monfared, Han, Sheehy, Bexton, & LeLorier, 2006). These high rates of cessation are arguably the result of some combination of the controversies that have been presented: significant treatment side effects, questionable efficacy, and a sense of unease with explanations for depression that rely primarily on biomedical hypotheses.

The trajectory of antidepressants has been remarkably similar throughout the various pharmaceutical iterations. From the initial creation of MAOIs through to TCAs and modern SSRI and SNRIs, these medications have often been met with initial hope and optimism that has ultimately given way to more sobering clinical realities. Interestingly, in spite of research findings that call into question the efficacy and safety of second-generation antidepressants, they continue to be widely prescribed. This disconnect points to the confounding nature of depression as well as the strength of the biomedical discourse (not to mention the pharmaceutical industry that relies on and promotes a biomedical discourse). It also points to the dearth of options physicians in primary care have for helping patients who seek to ameliorate their depressive symptoms.

Primary Care

It is important to situate this discussion about antidepressants within the context in which they are most likely to be prescribed. Primary care has been the de facto system of mental health treatment in North America since the 1970s or earlier, when policies of deinstitutionalization were aggressively pursued by governments following widespread introduction of antidepressants

and other psychotropic medications (Lieberman, 2003). Over the past 20 years, depression treatment has overwhelmingly been managed by family physicians (also known as general practitioners or GPs) within a primary care model (Mitchell, Vaze, & Rao, 2009). Treatment of depression in primary care is no small undertaking as it has been argued that up to 70% of people who visit a general practitioner report symptoms of depression (Robinson et al., 2005) and physicians have reported that depression is the second most common condition they encounter in primary care (Lewis, 2001). Primary care treatment for depression typically includes antidepressant medication, and 70% to 80% of all antidepressants are prescribed in primary care (Mojtabai & Olfson, 2008).

Despite the work family physicians are doing in this demanding field, they have reported having difficulty diagnosing and treating depression. For instance, physicians reported experiencing uncertainty with regard to the most appropriate criteria for diagnosing depression (Andersson et al., 2001) and have suggested that diagnosing depression is a complex and difficult task (Thomas-MacLean, Stoppard, Miedema, & Tatemichi, 2005). Research has also suggested that time pressures constrain physicians' treatment of depression in primary care (Pollock & Grime, 2003) and that physicians have limited access to secondary services such as psychiatry and psychology due to the scarcity of these resources and strict referral protocols (Hyde et al., 2005). Perhaps it is for these reasons that the quality of care for depression has not significantly improved in the past 20 years (Croghan, Schoenbaum, Sherbourne, & Koegel, 2006), despite an increased focus on the quality of care for people with mental illness (Institute of Medicine, 2005), practice guidelines put forth by the Canadian Network for Mood and Anxiety Treatments (Kennedy, Lam, Parikh, Patten, & Ravindran, 2009), and the publication of high profile reports on mental illness (Health Canada, 2002; The Standing Senate Committee on Social Affairs, Science, and Technology, 2006).

Challenges in the management of depression in Western models of primary care are due, in part, to the likelihood that constellations of discrete symptoms that clearly relate to clinical definitions of ‘depression’ are not often neatly presented to family physicians for diagnosis and treatment. Instead, primary care is treated as a “first port of call” (Murray, Charles, & Gafni, 2006, p. 206) for patients who more frequently express numerous undifferentiated symptoms that are potentially related to multiple combinations of diagnoses and personal circumstances. In particular, patients who meet clinical criteria for depression often present to their general practitioner with complaints that are not likely to be recognized as prototypical symptoms of depression: nonspecific pain, general malaise, decreased energy, insomnia, and headaches (Lieberman, 2003). The challenge in recognizing depression in primary care is heightened for the many patients who do not easily volunteer highly personal information.

Those critical of a biomedical understanding of depression have long argued that the line between a diagnosis of depression and problems of everyday living is exceedingly blurry, and physicians themselves have begun to echo this critique. Though it is certainly common (and expected) for physicians to take up a biomedical understanding of depression, research has suggested that family physicians acknowledge that the task of determining whether a given presentation of depression constitutes ‘illness’ or ‘sadness’ is subjective, problematic, and ultimately contributes to the medicalization of problems of everyday life (Hyde et al., 2005; Maxwell, 2005; Stoppard et al., 2008). This dissonance further challenges physicians’ management of depression within primary care (Thomas-Maclean et al., 2004). It is perhaps not surprising that a recent systematic review of qualitative research on general practitioners’ management of depression suggested that most physicians continue to regard antidepressant medication as the standard in their management of depression because antidepressants are either

seen as the most helpful available intervention or due to the perception that there are limited other available options for managing depression (McPherson & Armstrong, 2012).

This conflict related to the utility of offering pharmaceutical treatments for everyday problems points to an important dilemma faced by physicians, who have little that they are able to offer depressed patients other than antidepressants. It has been suggested that (a) if a patient brings a problem to a GP and (b) the problem can be addressed through a “bio-mechanical approach to medicine” (Toon, 1999 as cited in Murray et al., 2006, p. 207), then such a problem is well suited to a primary care approach. However, it is also acknowledged that this limited definition of the purpose of primary care misses the more humanistic and empathetic role that physicians are expected to take up as witnesses to patient suffering (Dowrick, 2009) and potentially ignores the most indispensable of physician skills: open communication, active listening, and a flexible approach to problem solving. With these potentially competing roles in mind, physicians’ reports of dilemmas associated with managing depression raise important questions about whether primary care is really the most appropriate setting within which to manage depression.

Treatment decision-making constructs. Despite its limitations, primary care has traditionally been the most widespread and predominant approach within which depression is managed in North America. Of course, ways that patients and physicians understand and participate in primary care have evolved and transformed over the years. In the following sections, I provide an account of the historical trajectory of primary medical care. This account can be understood by considering a continuum of treatment decision-making. On one end of the continuum is a highly conventional and paternalistic model of treatment decision-making that features the physician as the decision maker. On the opposite end are models that feature the patient in the principal decision-making role with the physician relegated to supplying medical

information and patient-directed treatment(s). In the relative (and crowded) centre of the continuum lie joint approaches to treatment decision-making. For each set of models, I explore the defining aspects of how information is shared, how deliberation occurs, and whether it is primarily the patient, the physician, or both who assume responsibility for the final decision-making action.

A paternalistic model of treatment decision-making. Traditionally, the medical model of care in which patients have sought help for illness and disease in North America has been a highly paternalistic one. Within this model, patients take up the role of passive dependents and physicians act as the authoritative experts and treatment gatekeepers (Charles, Gafni, & Whelan, 1997). Ingelfinger (1980, as cited in Gillon, 1985) summarized this approach quite candidly when he stated, “if you agree that the physician’s primary function is to make the patient feel better, a certain amount of authoritarianism, paternalism, and domination are the essence of the physician’s effectiveness” (p. 1971). Gillon (1985) would seem to concur when he claimed, “sometimes one has as a doctor to be paternalistic to one’s patients – that is, to do things against their immediate wishes or without consulting them, indeed perhaps with a measure of deception, to do what is in their best interests” (p. 1971). Of course, in matters of medical emergency or severe acute illness or injury, one expects medical practitioners to act quickly to save a life or reduce the chances of significant disability, and in some instances these actions must occur with little or no consultation with the patient. However, these quotations seem shocking and antiquated when considering the current expectations around ‘patient-centered care’ for those patients who are able to participate in the decision-making process. It is sobering to consider that such statements appeared in distinguished peer-reviewed journals not that long ago. In order to make sense of the development of these contentious discourses of paternalism, we must return to the man who is recognized as first describing melancholia as a mental disorder: Hippocrates.

The origins of medical paternalism. A paternalistic approach to medicine is traced at least as far back as that influential pledge of ancient Greek practitioners of medicine: The Hippocratic Oath. Thought to be written in the fourth and fifth centuries BCE, The Oath and other essays make up the larger collection known as the *Corpus Hippocraticum* (Chadwick & Mann, 1978). A translation provided by Edelstein (1943, as cited in Antoniu et al., 2010) describes the Hippocratic Oath as containing various philosophies and guidelines, including a short argument on the value of human life, the importance of confidentiality and good clinical skills as well as the ethical use of those skills. Though Hippocrates's name is formally attached to this collection, many unknown authors were involved in the writing of these texts over the course of perhaps hundreds of years. As Antoniou et al. (2010) suggested, the Hippocratic Oath is still practiced and taught today and represents an enduring "moral basis and the ethical values" for those who practice medicine (p. 3075). Neither Edelstein's (1943, as cited in Antoniu et al., 2010) nor Chadwick and Mann's (1978) translation of the *Corpus Hippocraticum* include any specific reference to 'paternalism;' however, these translations clearly feature physicians' contributions to the practice of medicine and delineate potential actions available to physicians given a range of patient presentations, with little mention of the patient's role in the process or any rights to self-determination that patients might otherwise have.

One of the defining principles of the Hippocratic Oath, and one that is routinely referred to, is the need for physicians to keep their patients from harm to the best of their ability and judgment. This aim, as Gillon (1985) argued, trumps any potential need to consult with patients about their treatment wishes, offer explanations of likely consequences, or provide descriptions of alternative courses of action. Such an approach would have been particularly relevant when harm was inevitable and the desire to prevent additional suffering was great. As an example, as late as the 1970s it was not uncommon for North American physicians to deliver bad news to

families rather than the patient him or herself. This practice was an attempt to reduce the patient's suffering as he or she was often experiencing great pain, highly unpleasant symptoms, confusion, and misery. The paternalistic physician acted as a guardian of the patient's well-being and attempted to reduce suffering whenever possible. One can certainly question just how this type of approach was likely to achieve this aim while at the same time acknowledging the beneficent intent behind it.

Challenged assumptions of paternalism. Given that some 2500 years have passed since the Corpus Hippocraticum was written, it is somewhat surprising that significant change in Western medicine (from a paternalistic approach toward one that considers the patient as a more active participant) has occurred only over the last 30 to 40 years. Part of the reason for this inertia may be the well-engrained assumptions that served to maintain a paternalistic discourse for so many years. For example, Brody (1980) provided an interesting account of several factors that were argued to maintain a paternalistic approach to healthcare, including physicians' possession of an esoteric body of knowledge; patients' lack of maturity and intellectual capability; and the perception that providing patients with information about their medical condition could induce anxiety and lead to an increase in unnecessary suffering. Many of these assumptions had little or no evidence to support them and simply failed to maintain relevance as new ways of conceptualizing treatment approaches gained ground.

However, other assumptions about the utility of a paternalistic approach to treatment were not as easily countered, and might help to account for the longstanding deference to authority that was common in North America throughout the 1960s and 1970s. Charles, Gafni, and Whelan (1999), in their review of their own framework of shared decision-making, explored long held assumptions about paternalistic approaches to treatment, including that a single best treatment exists for most illnesses, that physicians are aware of this treatment and are in the best

position to assess the potential positive and negative outcomes of a given treatment, and that physicians are legitimately invested in treatment decisions due to their professional concern for their patients. While it is likely that these assumptions are still applicable to some circumstances some of the time, over the last several decades a variety of pressures began to challenge these claims and promote discussion and research on the necessary role of the physician and patient in healthcare decision-making.

Evolving approaches to treatment and to chronic disease models of healthcare were one such influence that generated questions about many of the assumptions underlying a paternalistic approach to healthcare. Over the past 30 years, researchers have suggested that there are significant trade-offs in terms of benefits and risks associated with various treatment options, and that a single best treatment is often quite rare (Charles et al., 1999; Eddy, 1990). As well, the notion that physicians are aware of the best and sole treatment for a given disease has been brought into question through research findings that suggest that physicians routinely approach patient conditions quite differently, even though treatment guidelines and accounts of ‘best practices’ have been suggested (Baiardini, Braido, Bonini, Compalati, & Canonica, 2009; Cabana et al., 1999). While it certainly can be argued that physicians are just as invested in prudent treatment decisions for their patients as they ever were, over the last three decades there has been increasing recognition that it is the patient and not the physician who must live with the consequences of any decision that is made. Unsurprisingly, it is hardly a straightforward task to determine what a patient’s best interests actually are without involving them in the process of treatment (Schneiderman, Kaplan, Pearlman, & Teetzel, 1993). This greater recognition of the trade-offs of treatment benefits and risk, differing treatment approaches to the same condition, and the importance of patient involvement in treatment run counter to status quo assumptions

about medical treatment and undoubtedly contributed to the protection of basic patient rights, and encouragement of patient autonomy and self-determination.

Despite that a strictly paternalistic approach to primary care is largely a thing of the past, there are those who remain uneasy with the absoluteness of the shift toward increased patient involvement in treatment and argue that challenging philosophical questions are raised in such instances. For example, if one accepts that physicians typically have more information upon which to determine a given course of treatment (which admittedly, is not universally accepted) and if this treatment should confer a survival advantage, then might it not be considered ethical for a physician to strongly encourage or even insist on this treatment to a patient? Is conferring a greater chance of survival or even symptom improvement not the physician's primary purpose? These are thorny ethical questions that are still relevant even though paternalistic approaches to treatment are less common than they once were.

Of course, the utility of a paternalistic approach need not be considered in an all or nothing fashion, and there are those who attempt to recognize the importance of patient involvement while still claiming that the physician should have a predominant role in the treatment decision-making process. These ideas will be explored in a following section, as they are hardly compatible with the paternalism that has previously been depicted and instead fit more with current examples of joint approaches to treatment decision-making that are characteristic of a more equal relationship between patients and physicians.

Patient-directed models of treatment decision-making. On the opposite side of the decision-making continuum are patient-directed models of treatment decision-making. A completely patient-directed model would, at the most basic level, include the physician in the most limited role possible, perhaps as a sort of technician whose only role is to answer specific medical questions and prescribe a treatment that the patient determined independently. Such a

model has many practical issues and has not been presented in the literature to my knowledge. Rather, I use *patient-directed models of treatment decision-making* to refer to an overarching group which includes different approaches that feature the physician in a secondary role to that of the patient. Here, information sharing typically goes in one direction as the physician shares medical information with the patient. The patient would then deliberate on his or her treatment options before making a decision, in most cases independently of the physician. Within patient-directed models, the physician is still able to direct the patient's attention toward certain treatments and away from other treatments as they see fit; however, conflict would almost certainly occur if the patient desired a treatment that the physician felt was not indicated or not safe. Patient-directed approaches are typically seen as affording the patient the highest degree of autonomy possible in treatment decision-making. As such, these approaches to treatment decision-making would not likely be applicable for patients with very severe symptoms or disease processes that might compromise their consciousness, their capacity to make informed decisions, or their ability to communicate.

Patient-directed models of decision-making in Western health care are largely responses and attempts to compensate for the flaws and drawbacks of the paternalistic approach (Charles et al., 1999). In a sense, all approaches to treatment decision-making that followed from paternalism are responses or reactions to the paternalistic approach that dominated medicine for hundreds of years. To understand the development of this response to paternalistic treatment decision-making, one must consider the social catalysts of the patient rights movement and consumer rights movement.

The patient and consumer rights movements. The patient rights movement of the 1960s and 1970s as well as the consumer rights movement that followed in the 1980s and 1990s are frequently cited as contributing toward a much more equal relationship between physician and

patient, in similar, yet ultimately quite different ways (Charles et al., 1999; Donahue, 2006; Mariner, 1999). The goal of the patient rights movement was to mandate physicians and other health professionals to provide essential information to patients about their treatment options and to protect the rights of patients through a process of patient consent (Hartman & Liang, 1999; Mariner, 1999). Though the concept of ‘informed consent,’ which grants explicit recognition of patient autonomy and self-determination in treatment decision-making, was first mentioned in a legal context in 1914, it did not attract any significant attention until some 50 years later (Brody, 1980).

It was during the 1950s and 1960s that disillusionment and discontent with medical treatment was at a high point in North America, as evidenced by a high rate of malpractice suits and loud calls for increased patient involvement in medical treatment (Brody, 1980). More comprehensive ‘informed consent’ requirements followed, including the adoption by the courts of the ‘reasonable physician’ test in 1950 (requiring physicians to share as much information as an experienced physician would in a given situation), which evolved into the more patient-centered ‘reasonable person’ test in 1975 (requiring physicians to disclose information that a reasonable person would want to know in a similar situation; Hall, Prochazka, & Fink, 2012). As essential patient rights began to be enshrined in law, practices began to change swiftly. For example, 90% of physicians surveyed in 1961 preferred not to tell cancer patients their diagnoses; by 1979 research suggested that 97% of physicians preferred to disclose a diagnosis of cancer (Laine & Davidoff, 1996).

Unlike the patient rights movement, the emphasis of the consumer rights movement that produced general consumer protection laws in the 1980s and 1990s was on equalizing the relationship between buyers and sellers (Donahue, 2006). However, the implementation of each was similar in the sense that sellers were required to disclose information about the products they

sold so that consumers could then compare and make informed choices in the same way that physicians were required to disclose information about treatments to patients (Mariner, 1999). Consumer protection laws also brought in minimum safety standards for products and banned deceptive or false advertising. These broad consumer protections certainly impacted health care treatment in an indirect fashion by encouraging the wider population to be more critical and to ask questions of their health care providers (Quill & Brody, 1996).

This general movement that applied to all customer-oriented industries ultimately led the way toward a strong consumer movement within medicine, which can be understood as related to the popular notion of 'patient-centered care.' Patient-centered care is not a specific approach to managing treatment decisions but is instead an overarching approach to healthcare delivery which can be broadly considered to be a medical philosophy that is congruent and responsive to patient needs and preferences (Laine et al., 1996). Moloney and Paul (1991) argued that those who make up the baby boomer generation, and those generations that have since followed, began to have higher expectations when it came to consumer notions of choice, information, and comparability which inevitably applies to their seeking out of hospitals, physicians, and even specific treatments, particularly in America where various examinations and procedures may be associated with some form of monetary cost.

The weaknesses of the Western medical system have been argued to have contributed to the rise of the consumer movement within medicine. This is due to what was generally perceived to be a decline in those basic physician skills and expectations associated with bedside manner, empathy, active communication, and time spent with patients seemingly in favour of an increase in focus on diagnostic specificity, pathophysiologic processes, and managed care principles (Moloney et al., 1991). The consumer movement and, to a lesser extent, the patient rights movement is credited with a return to a focus on basic physician skills and on patients' thoughts,

feelings, values, and desires. Others have argued that the consumer movement within Western medicine was more than just an emphasis on the patient experience and was instead evidence of a more fundamental shift in the delivery of healthcare to patients who once occupied the dependent ‘sick role’ and are now much more invested in their treatment (Haug & Lavin, 1981). The consumer movement and patient-centered care philosophies can thus be argued to be important drivers of the narrowing of the ‘competence gap’ between physician and patient which has allowed for a more equal relationship between those seeking health care and those delivering it.

In the following sections, I explore some of the most prevalent models of patient-directed treatment decision-making available in the literature. While those who advocate for the level of patient autonomy depicted in the following patient-directed models of treatment decision-making might differ in what they title their models, the approach to treatment decision-making is largely the same: allowing the patient as much control and autonomy in the treatment decision-making process as possible.

The independent choice model. In this model presented by Quill and Brody (1996), the physician’s role is to inform the patient of the treatment options and to provide information on the possible benefits and drawbacks of the available treatments, as well as their odds of success. The patient’s role is to weigh these options, ask questions, and ultimately make an independent decision. Another model, called the informed decision-making model (and described by Gafni, Charles, & Whelan, 1998), is essentially identical. The latter is presented as a model in which “the patient decides on his or her own after the doctor discloses information about benefits, risks, and alternate treatment options” (Wirtz, Cribb, and Barber, 2006, p. 118). The focus in these approaches is the transfer of information from the physician to the patient who, ideally, can understand the information and then make an appropriate decision. Whatever it is called, under

this model the physician is expected to answer the patient's questions objectively and must take precautions to keep their own opinions (no matter how strong) from the patient and avoid persuading or biasing the patient's treatment choice in any particular way.

The informative model. This model is very similar to the informed decision-making model and the independent choice model, though Emanuel and Emanuel (1992) delineated specific details of their model more completely than Quill and Brody (1996). For instance, they constructed a philosophy that is admittedly simplistic, though is of some utility in understanding their approach. They suggested that patients require two things prior to making an informed treatment decision: (1) knowledge of their own values and (2) illness-specific information or what Emanuel and Emanuel called "facts" (1992, p. 2). Following this line of thinking further, since patients are the sole knowers of their own values, all that is left to understand are the 'facts' of the illness. Under this assumption (which applies equally to other patient-directed models of treatment decision-making), it is the physician's duty to provide medical information in a manner in which the patient can understand and consider it within the context of their own values. In these treatment models, the patient is positioned ostensibly as the 'value haver' and the physician as the 'fact knower.' Though the physician will certainly have values of his or her own, there is an expectation that these values have no role in the treatment decision-making context.

These patient-directed approaches certainly minimize the drawbacks associated with paternalistic approaches to healthcare by prioritizing patients' personal values and autonomy above all else. However, an argument can be made that it is naive and simplistic to assume that a physician can transmit medical information without bias and withhold his or her own values dispassionately in the provision of treatment recommendations. There are also concerns that the technical gap between the physician's understanding of a given treatment option and knowledge about risks and benefits and that of the patient is real and difficult to cross in many instances

(Wirtz et al., 2006). Finally, challenging moral and ethical questions are raised when, for example, patients insist upon ‘futile’ treatments when these resources are better directed elsewhere (Truog, Brett, & Frader, 1992). In these circumstances, the physician’s role as ‘gatekeeper’ would effectively dissolve and their expertise and training could be roundly ignored in the name of patient autonomy. While patient-directed approaches to treatment decision-making may fit for some patients in some circumstances, these approaches have not been widely adopted, in part due to the perception that they reflect an inappropriate balance of patient autonomy and physician involvement.

Joint approaches to treatment decision-making. Lying somewhere in the centre of the continuum are joint treatment approaches. Though there are many different descriptions and conceptualizations of joint treatment decision-making, they can generally be differentiated from other approaches by their expectation of involvement from both physician and patient. Like patient-directed approaches, joint models of treatment decision-making were constructed in response to the paternalistic approach and their popularity has equally benefitted from the consumer rights and patient rights movements. However, the philosophy of patient autonomy that underlies joint approaches to treatment decision-making is much less stark than it is in the patient-directed models. For instance, proponents of joint approaches might argue that the patient autonomy that is so prized in patient-directed models is an oversimplification that equates autonomy with unrestricted choice of selection (Wirtz et al., 2006).

Emanuel and Emanuel (1992), in their description of models that fit the joint approach to treatment decision-making, take a more nuanced view of patient autonomy and define it as that which “requires that individuals critically assess their own values and preferences; determine whether they are desirable; affirm, upon reflection, these values as the ones that should justify their action; and *then* (emphasis added) be free to initiate action to realize the values" (p.11).

Joint approaches are built upon the assumption that a patient's beliefs and values are often not fixed and occasionally not even known to the patient. Thus, it is argued that there is a need for information sharing and deliberation with the physician in order to elucidate what is important to the patient and just how their priorities relate to the specific decision that lies before the two of them. Open dialogue with experienced and trained experts is argued to actually enhance patient autonomy rather than diminish it. Most of the joint approaches share the common requirement that both patient and physician must agree on the treatment decision, which affords physicians a version of the gatekeeper role that is in keeping with their training and expertise and at the same time allows the patient considerable agency and autonomy in the process.

The following approaches to joint decision-making are discussed: patient+ joint approaches, physician+ joint approaches, partnership models, the concept of concordance, and shared decision-making. Wherever possible, these approaches have been grouped to help organize and consolidate the many overlapping descriptions. As in the case of patient-directed treatment approaches, joint approaches to treatment decision-making would not be relevant for those patients whose health status does not allow them to communicate or otherwise participate in the decision-making process. Following my account of these joint approaches to treatment decision-making, widely held assumptions and arguments that shared decision-making is the 'best' approach to treatment decision-making are explored.

Patient+ joint models. I use the term patient+ to define models that broadly promote a joint approach but ultimately defer to the patient. In particular, these models account for the sharing of information between patient and physician and a joint deliberation about the patient's concerns. The final decision usually is jointly determined as well, but in the event of disagreement between the patient and the physician, the final decision-making lies with the

patient. Two prominent examples include the enhanced autonomy approach and the interpretive model.

Quill and Brody (1996) defined their enhanced autonomy approach as requiring that “the physician engage in open dialogue, inform patients about therapeutic possibilities and their odds for success, explore both the patient’s values and their own, and then offer recommendations that consider both sets of values and experiences” (p. 765). Emanuel and Emanuel’s (1992) interpretive model has many similarities; in their approach physicians attempt to “elucidate the patients values and what he or she actually wants” (p.6) and then use this information to recommend and help the patient select the most appropriate treatment available. Supporters of patient+ joint approaches would likely argue that they recognize that a power imbalance exists between the patient and the physician and might posit that an open dialogue within which biases can be explored does far more to safeguard and promote patient autonomy than the “artificial neutrality” that is characteristic of patient-directed models of treatment decision-making (Quill et al., 1996, p. 765).

Within the patient+ joint approach it is expected that through honest dialogue and exploration of both the patient’s and the physician’s thoughts and feelings, a common understanding of the issues and a mutual determination of the course of action will generally be determined. However, should disagreements be unable to be resolved it is the patient who retains the right to make the final decision, and does so independently if necessary. When the disagreements are fundamental in nature, the need to terminate the relationship with the physician might need to be explored.

Physician+ joint models. I use the term physician+ to define models that promote a joint approach but ultimately frame the physician as the lead role in decision-making. However, unlike my characterization of patient+ joint models, I would not necessarily suggest that the final

decision lies solely with the physician in the event of a disagreement. Instead, these models might be framed in a way in which the physician takes the lead in treatment decision-making while still involving the patient in the process of arriving at that decision. Two prominent examples include medical paternalism 2.0 and the deliberative model of treatment decision-making.

Corn (2012), in his call for a return to a “paternalism of a kinder, gentler variety” (p. 123), asked whether there is room for physicians to practice skilled listening followed by offerings of customized recommendations within a joint approach to treatment decision-making. Proponents of this paternalism 2.0 approach eschew the controlling, domineering aspects of paternalism that have previously been explored and instead promote a notion of the physician as one who makes the effort to discover what a given patient needs, determines the best approach to presenting treatment options (including ‘no treatment’ as an option in some instances), and offers a learned viewpoint and customized treatment recommendations.

Emanuel and Emanuel (1992) similarly framed their deliberative model of patient care as requiring that the physician provide “factual” (p. 4) information and elucidate the patient’s values while providing specific treatment recommendations that are in keeping with those values. Here, the physician has taken on the role of teacher, and “not only does the physician indicate what the patient could do, but, knowing the patient, and wishing what is best, the physician indicates what the patient should do” (Emanuel et al., 1992, p. 3). These two approaches are titled differently, but share common themes involving a physician who attempts to elucidate the patient’s desires about treatment and then uses this information to provide customized medical guidance and recommendations. In both cases, it is acknowledged that the patient must ultimately agree with what the physician has recommended, and it is for this reason that physician+ models can be considered joint decision-making models.

Partnership models. Partnership models of treatment decision-making include a broad group of approaches, including contractual models (Quill, 1983) and informed-shared decision-making approaches (Towle & Godolphin, 1999). These models do not emphasize the patient's or the physician's role but do have in common a very deliberate and conscientious approach to achieving consensus between physician and patient. In this sense partnership models are closer to a truly joint approach than the previous two approaches that have been explored.

The contractual approach that Quill (1983) depicted is quite fittingly titled, since a contract between the patient and physician is a defining aspect of this and other partnership approaches to treatment decision-making. Proponents of partnership models argue for a deliberately negotiated verbal (or written) contract between physician and patient, particularly for those patients with complex presentations and issues. Quill (1983) argued that a partnership fortified with such a contract allows both patient and physician to more freely explore their own values and principles, which will more likely result in a treatment plan that is mutually agreeable to both parties.

Unlike the patient+ joint approach that was explored, treatment decisions are not ultimately up to the patient in partnership approaches, but are instead determined by consensus between physician and patient. A lack of consensus is essentially understood as a breach of the contract on one side or the other, which may result in a re-negotiation of the contract, or the dissolution of the treating relationship (Towle et al., 1999). Since approaches to understanding health problems and treatments can change throughout a treatment relationship, any contracts that are in place must be proactive and dynamic if they are to be of much utility. Partnership approaches very much seek to find a balance between allowing room for the physician's contribution and challenging authoritarian approaches to health care.

Concordance. Concordance is a term that is frequently used in the context of joint approaches to treatment decision-making; however it does not apply in this context in the way that it is frequently used. The notion of concordance was first presented by the Royal Pharmaceutical Society of Great Britain in 1996 (Cushing & Metcalfe, 2007). The use of this term differs from those treatment decision-making approaches that have previously been explored in the sense that it was introduced to replace terms such as ‘compliance’ and ‘adherence’ which are typically used to describe a patient’s ability to follow through with their physician’s treatment recommendations. Compliance and adherence were increasingly seen as promoting an unequal and paternalistic approach to pharmaceutical treatment and the impetus behind their reframing occurred alongside the emphasis on patient-centered healthcare that was occurring in the 1990s (Jordan, Ellis, & Chambers, 2002). While ‘concordance’ is occasionally used as a general term to indicate a joint approach to decision-making, it can more accurately be understood as an outcome of a treatment decision-making process that involves a therapeutic alliance and negotiation between the physician and the patient. The goal of all joint decision-making approaches that result in a treatment should, therefore, be concordance; however an agreement that is concordant is not necessarily compatible with principles of joint decision-making. For instance, Wirtz et al. (2006) suggested that a treatment decision that involved a complete deference of the decision by the patient to the physician could still be considered concordant though it would inevitably violate certain principles of most joint decision-making models.

Shared decision-making. There are many ways of defining approaches to joint decision-making, which can make it quite difficult to organize this literature (Makoul & Clayman, 2006). To add to the challenge, many of these various ways of defining joint approaches have significant overlap and few criteria that differentiate one from another (Moumjid, Gafni,

Brémond, & Carrère, 2007). Fortunately, there is one construction that has stood out as the most widely agreed upon and referenced model. Known simply as ‘shared decision-making’ (and perhaps the widespread acceptance of this approach is, in part, owed to the ordinariness of its title), Charles et al. (1997) are usually credited with first using this term and providing its definition. They summarized their model as requiring four characteristics that must be met if the decision-making process is to be considered shared: (1) there must be at least two people involved (usually a physician and a patient); (2) both parties must take steps to participate in the decision-making process; (3) there must be an exchange of information between doctor and patient; and (4) a treatment decision is made and both parties must agree to the decision. It is this fourth criterion that differentiates this model from the patient+ joint approaches and ties it to the partnership models, though the need for a deliberate contract is not in place here. In 1999 Charles et al. updated their model by delineating different phases of treatment decision-making, adding specific information exchange and deliberation phases to the decision-making process (Charles et al., 1999). Their updated model also acknowledged the dynamic nature of treatment decision-making and attempted to respond to critics by suggesting that the treatment decision-making process is flexible and can shift and change from phase to phase.

Much has been written about joint approaches to treatment decision-making in the research literature, and about a shared decision-making approach in particular. This topic has generated a large body of research, and shared decision-making has been heralded as a ‘paradigm shift’ in primary care (Coulter, 1997). Looking purely at the number of publications, as many as 342 articles featuring shared decision-making in the context of physician – patient interactions were published (and available via Pubmed) in a 16-month span between 2003 and 2005 (Makoul et al., 2006). The shared decision-making model’s position as a ‘middle ground’ between more extreme possibilities of paternalism and patient-directed approaches to treatment

decision-making undoubtedly has contributed to the research interest in shared decision-making (Cribb & Entwistle, 2011; Makoul et al., 2006). This model is increasingly being advocated as the most ethical and ideal model of treatment decision-making when two or more clinically reasonable treatment options are available (Charles et al., 1997; Coulter, 2007; Elwyn et al., 2010).

Despite the broad support for shared decision-making, research investigating whether or not shared decision-making is widely implemented in Western models of primary care suggests that physicians are more confident about the extent to which they enact this particular approach than is the case in actual practice (Karnieli-Miller & Eisikovits, 2009; Légaré, Stacey, & Forest, 2007; Stevenson, Barry, Britten, Barber, & Bradley, 2000). One reason for the discrepancy between the wide acceptance of this approach to decision-making and comparatively lower levels of adoption in practice might be that physicians often underestimate the degree of involvement their patients actually desire (Cox, Britten, Hooper, & White, 2007). Of course, it must also be considered that many patients are quite happy to defer important decisions to their physician (Levinson, Kao, Kuby, & Thisted, 2005; Robinson & Thompson, 2001).

The evidence for the benefits of a shared decision-making treatment approach for depression is favourable, but hardly conclusive. For instance, Swanson, Bastani, Rubenstein, Meredith, and Ford (2007) concluded that patients with major depressive disorder who participated in shared decision-making (i.e., were given an explanation of their health problems and were involved in making treatment decisions) were more satisfied with their care over a period of 6 months than those who did not participate in their care. However, it has been suggested that many depressed patients find it very difficult to maintain involvement in their treatment due to the nature of depressive symptoms. It has also been argued that the standard shared decision-making approach (i.e., the one delineated by Charles et al., 1997) may not be

effective for many patients presenting with depression without significant adaptations based on the severity of the depression (Simon, Loh, Wills, & Härter, 2006).

A concern has been presented that if there are benefits associated with treatment outcomes for patients with depression, such benefits do not appear to be directly related to a shared decision-making approach to treatment itself. Instead, the link between patient involvement in the decision-making process and better outcomes appears to be mediated by increased antidepressant medication adherence and lower treatment dropout rates, both of which are merely associated with shared decision-making (Loh, et al., 2007). This claim suggests that benefits associated with shared decision-making for patients with depression may be more indirect and not necessarily attributable to this particular approach to treatment decision-making (Loh, Leonhart, Wills, Simon, & Härter, 2007). More research needs to be done in order to delineate further whether or not these indirect effects are common to other approaches to treatment decision-making before any conclusions can be made about the utility of a shared decision-making approach for the treatment of depression.

Limitations of treatment decision-making constructs. While an exploration of the historical trajectory of popular Western treatment decision-making models can be helpful in understanding the contexts within which patients and physicians are likely to work, it must be recognized that these models are themselves social constructions. Physician and patient discussions and meetings are always uniquely co-created actions that do not neatly fit into categories such as the ‘independent choice model.’ Arguments raised in contesting these categories typically point to the confusion and lack of consistency in the terms used to differentiate one approach to treatment decision-making from another, to simplistic determinations of patient and physician involvement in decision-making, and to an overreliance on patient choice as the ultimate determination of patient involvement.

Lexical overlap, conflicts, and absences. In grouping the many individual approaches to treatment decision-making into broader categories such as patient-directed models and joint models of treatment decision-making, I have endeavored to provide a framework for what is very crowded lexical terrain. It is hardly surprising that many of the terms overlap, and that such overlap is particularly true in relation to various joint approaches to treatment decision-making. However, the extent of the overlap is staggering and may not be entirely apparent from the manner in which I presented these treatment approaches.

The definition of shared decision-making put forth by Charles, Gafni, and Whelan (1997) is, for the most part, widely agreed upon. Despite this consensus, in their review of research articles that focus on shared decision-making, Makoul and Clayman (2006) identified that only 2 of 31 separate concepts used to describe shared decision-making appeared in more than half of the conceptual definitions. Furthermore, over 60% of the articles they reviewed failed to provide a definition of ‘shared decision-making’ at all. It has been argued that shared decision-making might be left undefined in so many research articles and more generally amongst physicians and patients because its definition appears self-evident (Charles, Whelan, Gafni, Willan, & Farrell, 2003). In any case, this lack of specificity has contributed toward the considerable challenges that patients, physicians, and researchers face in determining what it actually means to enact specific approaches to decision-making, how to recognize when one or another is occurring, what constitutes full or adequate involvement by physicians or patients, and how to study it (Moumjid et al., 2007).

Narrow conceptions of decision-making involvement. Other critiques have focused on how the underlying assumptions about what constitutes patient and physician involvement in decision-making tend to be extremely narrow, in some cases limited only to the extent to which the patient or the physician makes the final treatment decision. It has been argued that such an

approach neglects the full process of dialogue and deliberation and reduces treatment determination to a largely technical task (Cribb & Barber, 1997; Wirtz et al., 2006). Entwistle and Watt (2006) argued that narrow considerations of involvement in decision-making models should be broadened to include the extent to which involvement occurs in all aspects of a treatment decision, from the framing of the problem, through to appraisal of potential solutions, implementation of a course of action, and evaluation of the treatment and process of decision-making. While some researchers have made efforts to broaden their models and to include more complexity, perhaps in response to such criticisms (e.g., Charles et al., 1999), many other models remain quite limited in this regard (e.g., Emanuel et al., 1992).

The lure of choice. The focus on treatment choice and how choice is typically offered to patients represents another important occasion for critique of many treatment decision-making models. Patient choice is increasingly touted as an important (and, occasionally, sufficient) attribute of patient-directed and joint approaches to treatment decision-making, with some researchers arguing that an overreliance on implementing ‘choice’ can actually adversely affect patient decisions (Bryant, Bown, Bekker, & House, 2007). Some research based on choice versus no-choice comparison groups has suggested that the presence of choice or options can actually lead to biased decision-making and poorer decisions than when an option is presented alongside no choice (Bown, Read, & Summers, 2003). Statistically speaking, it is argued, people are more likely to be drawn to options (even if they are less desirable) than a selection that does not involve alternative options. Bryant et al. (2007), in their critique of treatment decision-making models on these grounds, suggested that physicians and patients would be far better served by a shift in focus from simply providing ‘options’ to encouragement of active thinking and appropriate decision-making on all sides. Ultimately, the lure of choice can be considered

another example of narrowly conceptualizing decision-making involvement but represents an interesting critique in its own right.

A critique of overlapping terminology, narrow definitions, and emphasis on one particular construct and not another can, in one sense, be considered a critique of models in general. At the same time, a narrow and truncated explanation of a complex idea is the basic feature of any model, and it is appropriate to recognize this assumption. However, the issue here is that the considerable research literature that both constructs and tests treatment decision-making models runs the risk of not only reducing complex co-constructions between patients and physicians to narrow categories but also risks reifying models that potentially fail to fit in any convincing or useful way onto real world practices.

Despite the critique offered, the various models do serve as a practical way of making sense of the array of treatment decision-making approaches that are in use while framing the historical trajectory from the paternalistic origins of primary care toward more modern approaches that feature increasing equality in the patient - physician relationship. The substantial shift in approaches to treatment decision-making and particularly the role of the patient in primary care has also allowed room for persuasive actions to develop that were much less possible within a paternalistic approach.

Persuasive actions within primary care. An incredibly expansive topic, persuasion research has been conducted under the auspices of a broad range of disciplines, theories, and methods that are quite outside the scope of the present research (Burgoon & Dillard, 1995). Persuasive actions have long been associated with meetings between patients and physicians and it is here that I situate this discussion. At the most basic level, persuasion can be argued to be talk that changes others' positions or behaviour (Eggly, 2009). Within a traditional paternalistic approach to healthcare, persuasive actions can be largely understood to be discursive tools

commanded by physicians and used to convince patients to undergo a particular diagnostic test or adhere to a particular treatment.

The research on persuasion within primary care generally assumes this one-way attempt at compliance-gaining and tends to focus on theories that explore complex models, including the goals-plans-action model (Dillard, 2004), the reinforcement expectancy theory (Klingle, 2004), and the transtheoretical model (Emmons & Rollnick, 2001), or various strategies physicians use to persuade. Some of these strategies are straightforward and involve the provision of patient education or neutral directives (“there are several dietary changes I would like you to make”), while others are based on positive and negative reinforcement expectancies (“Changing eating habits is very difficult, but I know you can do it” or “If you won’t follow this advice, you’re going to continue to have problems;” Klingle, 2004), among others (Cialdini & Guadagno, 2004; Karnieli-Miller et al., 2009). It will come as little surprise that these attempts often fall short of their presumed intent. Whatever the strategy enacted, physicians’ attempts to persuade have routinely been challenged by patients, with low treatment compliance (or low concordance, to use the more recent term) being the rule rather than the exception (van Dulmen et al., 2007).

In an era of shifting approaches to primary care and increasing recognition of the role of the patient, this conceptualization of persuasion as something that physicians do to patients is starting to appear as outdated as paternalistic approaches to treatment decision-making. However, the notion that patients equally persuade the physician has been little explored. Persuasive actions need not be considered synonymous with coercion or manipulation nor must they be reduced to compliance gaining tactics but can instead be considered as more everyday reciprocal actions between people acting intentionally and effectively (Eggly, 2009; Shaw & Elger, 2012). Indeed the notion of mutual persuasion that recognizes the involvement of both the

physician and the patient is much more in keeping with more modern conceptualizations of primary care, and particularly with joint approaches to treatment decision-making.

The consumer and patient rights movements have also allowed room for persuasive actions that were likely to have been much less available before these social movements. Pharmaceutical companies, for instance, seized an opportunity and began directing their marketing dollars toward extolling the virtues of their products directly to patients, rather than exclusively to physicians. As the treatment pendulum shifted away from the physician as the primary decision maker in the direction of the patient, it has also become much more commonplace for patients to advocate for their own treatment preferences, as is the case with patient requests for antidepressants.

Direct to consumer pharmaceutical advertising (DTCPA). Until the 1990s, pharmaceutical companies advertised their products almost exclusively in medical journals, with the presumed intent of convincing physicians to prescribe a particular drug. Over the past 20 years, however, this approach has increasingly given way to advertisements that target consumers directly through television and magazine placements. As an example of the extent of this shift, spending on DTCPA increased by 330% between 1996 and 2005 (Donahue, Cevalco, & Rosenthal, 2007). Research has suggested that this form of marketing is certainly working. Spending on DTCPA positively correlates with increases in the number of prescriptions written for these drugs (Spake & Joseph, 2007), and as exposure to direct to consumer pharmaceutical advertisements increases, so too do requests for advertised medications (Mintzes et al., 2003). This shift from ‘push’ advertising (marketing directed toward physicians that attempts to persuade them to prescribe certain medications to their patients) to a strategy of ‘pull’ advertising (marketing directed toward patients that attempts to persuade them to request or inquire about a certain medication from their physician) is a striking example of the shift from physician-based

approaches to treatment decision-making to patient-based approaches (An, 2007; Bell, Taylor, & Kravitz, 2010).

Of course, DTCPA is not without controversy. The arguments in favour of these advertisements are that they provide valuable health information to the public about specific diseases and conditions, and result in increased health awareness, improved communication between patients and physicians, higher rates of concordance, and even increased health outcomes (Bonaccorse & Sturchio, 2002; Frosch & Grande, 2010). Arguments against DTCPA include that the information presented is biased and one-sided, and that these ads promote unrealistic expectations, encourage inappropriate usage of medications, and drive up unnecessary drug spending (Gilbody, Wilson, & Watt, 2005; Hollon, 2005). It would seem that most countries' legislation has fallen in favour of the latter arguments; America and New Zealand are the only nations that allow DTCPA that includes product claims (Abel et al., 2006).

Canada's geographical proximity to America and the immense cultural influence America wields (in the form of television programming and advertising, as well as magazine distribution) ensures that most Canadians, at one time or another, have seen direct to consumer pharmaceutical advertisements, though likely not to the same degree as most Americans. In keeping with this assumption, research by Mintzes et al. (2003) suggested, expectedly, that exposure to DTCPA was less in study participants from Vancouver, British Columbia compared to participants from Sacramento, California. They further suggested that Canadian participants were less than half as likely to request advertised drugs than their American counterparts. It is evident that DTCPA helped to further shift expectations about patient autonomy within primary care. Less evident is whether and how this style of advertising might influence a given request for antidepressants that a patient makes in Canada.

Patient requests for clinical services. Patient requests for clinical services are a phenomenon that would have been all but incompatible with a paternalistic approach to treatment; however, patient requests for specific diagnostic tests, specialist referrals, pharmaceutical treatments, and even surgical interventions are commonplace today. While Canadian research on this topic is quite sparse, it has been reported that as many as 25% of patient visits to primary care physicians in America are accompanied by a request for some sort of clinical service (Kravitz et al., 2003). As well, one-third of physicians in Finland (which has a similar government-funded healthcare system to Canada with no direct to consumer pharmaceutical advertisements) report ‘often’ or ‘very often’ receiving requests from patients for specific drug treatments (Toiviainen, Vuorenkoski, & Hemminki, 2005).

Patient requests for antidepressants. There is a large body of research concerned with the outcomes of patient requests for antidepressants specifically, and the results have largely supported the notion that if patients ask, they are likely to receive (Kravitz et al., 2005; Mintzes et al., 2003). Furthermore, when people were asked what their anticipated reactions would be to a physician who refused a request for a specific drug, nearly half said that they would be disappointed (Bell, Wilkes, & Kravitz, 1999). Of these disappointed participants, one-quarter indicated that they would attempt to persuade their physician otherwise or seek their request from another physician, and 15% indicated that they would consider terminating their relationship with their physician. These data suggest that once a person has made the decision to request a specific prescription medication from a physician (for whatever reason), he or she has an expectation that the medication will be provided and, indeed, it probably will.

These findings also suggest that, for those who request medications from their physicians, these decisions are associated with highly autonomous approaches to treatment decision-making for some patients (in the case of those who would shop around or terminate the relationship with

their physician), while for other patients there is an apparent willingness to share this decision with their physician (in the case of the more than 50% who indicated that they would not be disappointed by their physician's refusal). Of course, whether a given patient request is judged to be consistent with joint decision-making principles or patient-directed principles depends largely on the manner in which the request is made and the conversation that takes place between patient and physician.

Physician responses to patient requests for antidepressants. Limited research investigating physicians' reactions to receiving requests for antidepressants suggests that positions are quite polarized. For instance, it has been suggested that physicians find that such requests encroach on their authority and negatively affect the usual consultation routine (Tentler, Silberman, Paterniti, Kravitz, & Epstein, 2007; Toiviainen et al., 2005). Other research has suggested that physicians frame specific requests for antidepressants as resulting in improved history taking and suicide screening (Feldman, Franks, Epstein, Franz, & Kravitz, 2006) and an improved relationship between patient and doctor (Murray, Lo, Pollack, Donelan, & Lee, 2003).

Physicians have been argued to maintain and increase their involvement in the decision-making process following patient requests for antidepressants in some instances (Young, Bell, Epstein, Feldman, & Kravitz, 2008), yet appear to show low levels of involvement when faced with patient requests in other instances (Epstein et al., 2007). This finding could imply that patients construct requests in different ways and that physicians attempt to match their treatment decision-making approach with one they assume their patients prefer. Unfortunately, there is some evidence that physicians' perceptions of their patients' desired level of involvement are inaccurate in most cases. Cox et al. (2007) reported that physicians overestimate their patients' desired level of involvement in 45% of cases, accurately assess their patients' wishes in 32% of cases, and underestimate their patients' desire for involvement in 23% of cases.

Despite physicians' divided notions about the appropriateness of patient requests for antidepressant medication and questions associated with determining patients' involvement preferences, some research has suggested these issues have not necessarily resulted in a cautious position on prescribing. Though doctors recognize that about half of the specific requests for interventions they receive are clinically inappropriate, they go on to fill two-thirds of these requests regardless (Murray et al., 2003). Other research has similarly suggested that asking for medication dramatically increases the likelihood of a prescription regardless of clinical indication (Mintzes et al., 2003).

Of course, physicians, in their role as treatment gatekeepers, must refuse some requests for antidepressants some of the time. Unfortunately, the research on this topic is quite limited, perhaps due to the widely held assumption that antidepressants 'won't do any harm and might do some good' (Middleton et al., 2011). One recent study suggested that physicians use a variety of strategies when they refuse requests for antidepressants, including exploring the context of the request and explaining their rationale for denying it (a patient perspective based approach), offering an alternate diagnosis, treatment, or referral (a biomedical approach), or simply refusing the request outright (Paterniti et al., 2010). It is perhaps no surprise that of the patients who reported the highest levels of satisfaction, the fewest number had their requests refused outright with no explanation provided.

Conclusion and Outline of Present Study

A construct that spans eras and disciplines, depression is a topic that is virtually without limit. As a consequence, the practical need to impose boundaries on this introduction quickly became apparent. As my research topic focuses on patient requests for antidepressants, I have in turn chosen to approach this literature primarily from a position of exploring and critiquing the ambiguity and contradictions associated with Western medical constructions of depression and

its management in primary care. In this introduction, I have endeavored to provide a review of a multiplicity of discourses that have historically been available to explain and construct depression. The predominance of a biomedical explanation tends to overshadow other non-medical ways of making sense of depression, such as those that draw on more personal and social explanations. A biomedical explanation also tends to encourage a straightforward construction of the solution to depression: antidepressant medication. Developed with little planning and a certain degree of fortuity, SSRI and SNRI antidepressants continue to be prescribed in great numbers despite the high rate of patient discontinuation and the mounting claims that question their efficacy. One is left with the distinct impression that physicians' treatment options for depression are quite limited within the confines of Western medicine and primary care.

The shift from a paternalistic approach to treatment decision-making to a joint approach that involves greater patient involvement has been touted as a positive change and the best way to manage a range of medical issues in primary care, yet there is some uncertainty regarding the fit and utility of joint approaches to treatment decision-making for depression (Loh, et al., 2007; Loh, Leonhart, Wills, Simon, & Härter, 2007, Simon et al., 2006). Despite this uncertainty, patient requests for antidepressants do seem to be common occurrences within primary care visits. Considering only the end result, research suggests that patient requests tend to result in a prescription for antidepressants, even in some instances that might not clinically warrant it. This field of research is marked by considerable contradiction and ambiguity. I have endeavored to provide a critical summary that recognizes the complexity of the construction of depression and its treatment within a Western-approach to primary care while at the same time providing a practical boundary on this expansive topic.

Research Questions

The research questions that guide this work are as follows: how do physicians account for their decisions to endorse or deny patient requests for antidepressant medication and, in turn, how do patients account for requests for antidepressants they have made from their physician?

Rationale for the Present Study

Much of the research on the topic of patient requests for antidepressants that I explored in the introduction is focused on issues that are somewhat peripheral to the requests and the responses to these requests themselves and the accounts of these instances. For example, research questions that have previously been pursued include whether or not direct to consumer advertising influences patient requests (Gilbody et al., 2005; Mintzes et al., 2003), physicians' positions on patient requests for antidepressants (Tentler et al., 2007; Toivainen et al., 2005), and the extent to which patient requests influence physician prescribing behavior (Kravitz et al., 2005). No doubt these are important questions to examine; however, nomothetic assumptions that underlie these and similar queries allow for little recognition of the contested terrain of depression, the conflicting claims about the utility of antidepressant treatment, and the multiplicity of treatment decision-making approaches (within primary care alone) that make patient requests for antidepressant medication such an important topic. In attempting to narrow in on interesting questions that can be answered using statistical methods, most research on this topic fails to capture the complexity and contradictions that define this topic area.

The present research differs from the previously explored literature in terms of my focus on talk about the requests themselves and in my approach to this topic from a social constructionist epistemology. I have endeavored to explore this nearly limitless topic of depression under the assumption that it is a notion that has been constructed socially and has thus changed over time. Likewise, antidepressants were created not in a vacuum but in a historical

context that has important consequences for how they are used and viewed today. Finally, the Western approach to primary care can certainly be considered one of countless ways of organizing meetings between people who consider themselves to be ill and those who have taken up the role of healer. Using an epistemological approach that acknowledges that these constructs are contingent on people maintaining and reaffirming these ideas through language will allow me to conduct research that more thoroughly reflects the array of available perspectives on the topic and also allows me to better consider where we have been, and also where we are going.

Discourse analysis seemed a good methodological fit for my exploration of this topic, as utterances are of the most basic of requirements for decision-making to occur between individuals. It is a given that physicians and patients co-generate conversation during every meeting and, ultimately, decisions of enormous consequence are enacted through these conversations. However, physicians and their patients also perform actions in their conversations with others, and in so doing influence the broader social and political discourses and practices of which they are a part. Available discourses are continually being drawn upon, contributed toward, and, indeed, challenged through all forms of talk, and particularly through accounts. As a focus of analysis, accounts can be considered both social and interactive. They have been studied since at least the 1970s and have been suggested to be a good fit for research that examines phenomena that involve routine temporal sequences, as constructions of accounts are likely to feature the establishing of order on disparate or related events (Orbuch, 1997). Accounts can also be useful sites of analysis when actions of attribution (e.g., causality, responsibility, and/or blame) might be relevant, or when ambivalence or uncertainty is expected (Harvey, Orbuch, & Weber, 1992). As such, conversations between researchers and patients or physicians represent a very accessible and appropriate context for discourse analysis.

For Study 1, Dr. McMullen and I conducted interviews with family physicians. In these interviews we explored whether physicians encountered requests for antidepressants from their patients and, if so, their accounts of the strategies they used to endorse or deny those requests. In Study 2, I interviewed laypeople who had made requests for antidepressants from their physicians, and explored their accounts of these requests and the ways in which they framed these actions. Interviews were analyzed with a particular focus on the rhetorical strategies patients and physicians employed in these interviews when discussing their approach to requesting antidepressants (or responding to requests for antidepressants), how they discursively positioned themselves in relation to one another, and how their talk fit (or did not fit) with wider cultural discourses (Wood & Kroger, 2000).

This research has implications for our understanding of the treatment decisions made by both patients and physicians in relation to consultations where a request for medication has been made. It also provides an account of how some patients frame requests for antidepressants and how some physicians make sense of patient requests for antidepressants and how they justify their endorsement of these requests in some instances and not others. Finally, it offers some ideas about how some physicians and patients describe navigating the contradictory and contested terrain that is ‘depression.’ Indeed, these are timely issues. They speak to the shifting positions of ‘physician’ and ‘patient,’ the purpose of primary care, and our understanding of the construct of depression and its medical treatment in North America.

Study 1: Physician Accounts of Patient Requests for Antidepressants: Defining Limits of
Autonomy and Determining (In)appropriateness
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Abstract

Prevailing models of primary care treatment decision-making have changed drastically from those that frame physicians as decision makers to those that feature patients and physicians as equal partners. One example of the variable and changing model of Western health care is the patient request for clinical services. Joint approaches to treatment decision-making are frequently argued to be appropriate when varying degrees of risk and benefit associated with multiple treatment options exist, such as in the treatment of depression. We interviewed 11 family physicians and asked them whether they encountered, and how they managed, patient requests for antidepressants. Using a discursive analytic approach, we argue that (a) the physicians in our sample frame patients as primary treatment decision makers while framing themselves as defining strict limits on these decisions, and (b) they reported denying certain requests through what could be termed a patient-centered (and persuasive) approach to refusal. We discuss these actions in the context of physicians' attempts to balance opportunities to encourage patient autonomy while maintaining their role as gatekeepers.

Study 1: Physician Accounts of Patient Requests for Antidepressants: Defining Limits of Autonomy and Determining (In)appropriateness

In North America, depression is common (Patten et al., 2006) and its management overwhelmingly takes place by a family physician in primary care situated within the medical model (Mitchell, Vaze, & Rao, 2009). As many as 70% of individuals who visit their family physician report depressive symptoms (Robinson, Geske, Prest, & Barnacle, 2005) and physicians report that depression is the second most common condition they encounter in primary care, after hypertension (Lewis, 2001). It is perhaps no surprise that 70% to 80% of all antidepressants are prescribed in primary care settings (Mojtabai & Olfson, 2008).

Despite the extensive work family physicians (or general practitioners; GPs) are doing in this area, they report having difficulty recognizing depression, diagnosing it correctly, and treating it appropriately. For instance, physicians report that they experience uncertainty with regard to the appropriate criteria for providing a diagnosis of depression (Andersson, Troein, & Lindberg, 2001). Research also suggests that time pressures associated with general practice limit family physicians' treatment of depression (Pollock & Grime, 2003), and that support from secondary services (psychiatry and psychology) is limited because of scarce resources and rigid referral protocols (Hyde et al., 2005). These challenges run the risk of constraining physicians in their necessary 'gatekeeper' role of triaging access to diagnostic assessment, treatment, and specialist referrals (Paterniti et al., 2010).

The determination of normal versus pathological symptoms is a typical challenge for physicians working in general practice, which has been appropriately depicted as a "first port of call" for patients of all ages who exhibit myriad undifferentiated symptoms that are potentially related to multiple combinations of diagnoses and personal circumstances (Murray, Charles, and Gafni, 2006; p. 206). Accordingly, there are significant challenges in defining the types of

problems that most appropriately fit within the purview of the physician working in general practice and those that do not. While those critical of a biomedical understanding of depression have long argued that the line between a diagnosis of depression and problems of everyday living is exceedingly blurry and difficult to determine, physicians themselves have begun to echo this sentiment. There are several examples in the literature of physicians acknowledging that the determination of whether a given presentation constitutes ‘illness’ or ‘sadness’ (or something in between) is difficult, problematic, and subjective, and contributes significantly to the medicalization of problems associated with everyday living (Hyde et al., 2005; Maxwell, 2005; Stoppard, Thomas-MacLean, Miedema, & Tatemichi, 2008). Though it is evident that patients are approaching their physician with concerns about depression, physicians’ reports of dilemmas and ambiguities associated with managing depression within general practice suggest that there is some level of uncertainty with regard to whether depression can be appropriately addressed through a biomedical approach.

The Changing Model of Health Care

Traditionally, the most prevalent approach to treatment delivery in Western health care involved the physician in a dominant decision-making role and the patient as the passive recipient of health care. In the case of depression, this model might have been represented by the physician determining the appropriateness of an antidepressant medication based on its known efficacy and safety profile, and any known contraindications with other medications the patient was taking. This traditional model was a top-down, expert-driven approach to treatment built on assumptions that a single best treatment existed, that physicians were informed about this best treatment, and that they were bound by ethical practice expectations (Charles, Gafni, & Whelan, 1999).

Over the past 30 years, however, researchers have suggested that there are significant trade-offs in terms of benefits and risks associated with various treatment options, and that a single best treatment is quite rare (Charles et al., 1999). For instance, in the case of antidepressants, the evidence for efficacy of selective serotonin reuptake inhibitors (SSRIs) and serotonin - norepinephrine reuptake inhibitors (SNRIs) in mild to moderate depression is weak (Fournier et al., 2010; Kirsch et al., 2008; Middleton & Moncrieff, 2011). As well, discontinuation rates are exceedingly high, with as many as 55% of patients discontinuing antidepressants within the first 3 months, and 70% discontinuing within 6 months (Monfared, Han, Sheehy, Bexton, & LeLorier, 2006).

Proponents of the consumer rights movement of the late twentieth century have also contributed toward a changing model of health care by encouraging patients to be more assertive, to ask questions of their health care providers, and even to demand interventions that might have otherwise been withheld (Quill & Brody, 1996). The consumer movement, in combination with broad concern for the rising costs of health care and the multinational introduction of legislation that enshrines the patient's right to be informed about available treatments, have contributed to the 'treatment pendulum' swinging away from the physician as the decision maker (a paternalistic model) toward the patient as the decision maker (a patient-directed model).

In the centre of the continuum are a broad range of joint approaches to treatment decision-making. These approaches involve more of an equal relationship between the patient and the physician, and typically require agreement on both sides for a treatment decision to proceed. Shared decision-making (by far the most prominent joint treatment approach) was originally presented by Charles, Gafni, and Whelan in 1997. They defined it as involving a patient and physician, who must each take steps to participate in the decision-making process, exchange information, and make a treatment decision with which both parties ultimately agree.

This model is routinely argued to be the ideal way to manage a host of problems and diagnoses in primary care (including depression) when more than one reasonable treatment option exists (Coulter, 2007; Makoul & Clayman, 2006). Despite this assessment, shared decision-making is not as routinely implemented in primary care as proponents might wish (Légaré, Stacey, & Forest, 2007; Stevenson, Barry, Britten, Barber, & Bradley, 2000). Karnieli-Miller and Eisikovits (2009), for example, argued that their sample of specialist physicians advocated a shared decision-making philosophy but instead used persuasion and coercion to implement their treatments in their actual practice. Such a disparity between philosophy and practice might represent a concern for some physicians that enacting a shared decision-making approach would restrict their role as treatment gatekeepers.

Patient Requests for Clinical Services

Patient requests for specific clinical services are a stark example of this shift away from a paternalistic approach toward an increasingly patient-centered approach. It is a phenomenon that is entirely incompatible with a paternalistic approach to treatment; yet today patient requests for referrals for diagnostic testing, specialist appointments, and even medical treatments (including prescription drugs) are commonplace (Kravitz et al., 2003; Toiviainen, Vuorenkoski, & Hemminki, 2005). Whether patient requests are ultimately judged to be situated in the relative centre of the treatment continuum (i.e., acts consistent with joint approaches to treatment decision-making) or on one extreme end (i.e., instances of patient-directed treatment decision-making) largely depends on how patients and physicians construct these conversations.

Research is mixed with regard to physicians' positions about whether patient requests for antidepressants help or hinder the treatment process (Feldman, Franks, Epstein, Franz, & Kravitz, 2006; Tentler, Silberman, Paterniti, Kravitz, & Epstein, 2007). As well, research has suggested that physicians respond to patient requests for antidepressants by increasing their

involvement in some instances (Young, Bell, Epstein, Feldman, & Kravitz, 2008), but show low levels of involvement in other instances (Epstein et al., 2007). Despite these divided positions, some research has suggested that patient requests for antidepressants are granted easily (Kravitz et al., 2005; Mintzes et al., 2003). One published study has suggested that physicians use a variety of strategies to refuse requests for antidepressants when they are not indicated, including exploring the request using a “patient-perspective based approach” (p. 383), offering an alternative conceptualization of the problem, and referring to a mental health professional (Paterniti et al., 2010). This research further suggested that physicians refused requests outright in very few circumstances, in order to preserve the physician - patient relationship.

Little of the available research on this topic focuses on physicians’ accounts of managing patient requests for antidepressants or other clinical services and few studies attempt to take into consideration the changing context of primary care. Much of the research is focused on whether or not patient requests for antidepressants or other medications are likely to result in prescriptions (Kravitz et al., 2005; Mintzes et al., 2003) and the effect that these actions have on the patient-physician interaction (Feldman et al., 2006; Tentler et al., 2007) and these questions are generally approached using statistical methods within an experimental approach.

Comparatively little research has focused on the approaches physicians report using in their everyday practice to manage such requests. Through the present research, we intended to build on the findings of Paterniti et al. (2010) while expanding the focus beyond physician denials of patient requests. That is, we sought to engage physicians in conversations about how they respond to solicitations and how they arrive at decisions to either endorse or refuse requests for antidepressants.

Epistemology and Methodology

This research was undertaken using discourse analysis within constructionist

epistemological assumptions. Within this constructionist framework, we assume that knowledge is co-generated between interviewer and interviewee (and within and through their environment) and not simply available for objective discovery. Categories, concepts, and ideas are produced through the use of language, and words, in turn, constitute action. This research, and all knowledge creation, is therefore limited to the social context, time, and era in which it is generated (Burr, 1995).

In keeping with this epistemological approach, discourse analysis is a methodology directed toward the study of how language both describes things and makes them happen (Burr, 1995). For instance, it is through talk that patients and doctors formulate important health care decisions. Our discursive approach involved an investigation of accounts constructed between physician and researcher, as it is through accounts that order is imposed on events and in which attributions of causality, responsibility, and blame are typically made (Orbuch, 1997). In the present article, we examined physician accounts of patient requests for antidepressant medication and considered how these accounts spoke to broader social practices. Particular focus was placed on analyzing how physicians framed their patients' requests, the rhetorical strategies they employed in describing their responses to requests, and the implications of these discursive patterns for our understanding of depression and the current model of primary care.

Method

Participants

Recruitment was completed through a targeted mail out to each of the approximately 150 family physicians in a mid-sized western Canadian city. A copy of the letter physicians were sent is included in Appendix A. Physicians were invited to participate in an interview as part of a larger research program investigating how they make decisions to diagnose and treat depression. An honorarium of \$150 CDN was offered. Eleven physicians (six men) agreed to participate in

semistructured, individual interviews held over the course of several months in 2009. The physician interviewees ranged considerably in age (33 to 71 years old, with a mean age of 51.73 years), in their number of years in practice (between 3 and 41, with a mean number of years in family medical practice of 21.8 years), and in their type of practice (five on a fee-for-service basis in private practice and six salaried in publicly funded settings).

Procedures

Prior to recruitment, this project was given ethics approval by the Behavioral Research Ethics Board at the University of Saskatchewan. Participants provided verbal and written consent prior to the interview. They were made aware of the purpose of the research, and were reminded that they were free to rescind consent and participation at any point (see Appendix B). Individual interviews with each of the 11 participants were conducted in a quiet interview room. In the first part of the interview, participants were asked questions about their general diagnostic and treatment practices for depression, for the purposes of a related project. Following a short break, participants were interviewed about their experience of patient-initiated requests for antidepressant medication, which generated the data for this article. The combined interviews lasted between one and two hours and were audio-recorded using a digital recorder.

The questions that guided the second portion of the interviews related broadly to whether physicians encountered patients who made requests for antidepressants, and how they, in turn, addressed such requests. A complete list of interview questions is included in Appendix C. These questions were created with the purpose of initiating a conversation and with the intent of encouraging the physicians to frame their responses and the subject matter however they desired. Examples of questions included, ‘Have you ever felt that patients were requesting a prescription for antidepressant medication from you? If so, what did this look like?’ and, ‘Have your diagnostic or treatment practices ever been affected by patient requests for antidepressants? If so,

how?’ All participants provided accounts of having at least one request for antidepressant medication from a patient, and many presented these requests as a routine part of their practice.

Interviews were transcribed verbatim and efforts were made to remove all identifying information from the transcripts. Participants were given an opportunity to add, delete, and modify their written transcripts prior to analysis (a copy of the transcript release document is included in Appendix D). Although the majority of our interviewees declined to edit their written interview through this ‘transcript release’ procedure, a few did request minor phrasing changes or deletions of extraneous vocalizations (e.g., uh, ah).

Extracts were selected and analyzed through an iterative process of preliminary examination based on relevance to the research questions, review of related literature, comparison to other extracts under consideration, and further analysis. In particular, we paid close attention to the rhetorical strategies physicians described using to endorse or deny patient requests, and the ways in which physicians framed themselves and their patients. Jefferson (1984) notation techniques were employed for the extracts that were ultimately selected for analysis (see Appendix E for a complete listing of transcript notation techniques). We have endeavored to present a context for the conversations depicted in the extracts when the context is not apparent from the text itself.

Analysis

In the following sections, we explore two approaches to managing patient requests for antidepressants constructed by the physicians’ talk: (1) defining limits of patient autonomy and (2) determining (in)appropriateness. In this initial section, we explore how our interviewees framed the patient as the ultimate treatment decider while at the same time placed strict limits on these decisions. In the following extracts, (I) refers to the interviewer while (Px) refers to the physician interviewee (with ‘x’ used as reference to the participant number).

Defining Limits of Patient Autonomy

Extract 1.

1 I: . . . so it sounds like (.) a:
2 >pretty directly< °they° they would
3 make that request.
4 P8: Yep
5 I: Yeah?
6 P8: Yep
7 I: um a:nd >do they ever< make kind
8 of more subtle↑ requests or do you
9 get a sense that maybe that's kind
10 of what they're interested in but
11 they're not coming out and saying
12 it?
13 p8: >Yeah, I mean often they come in
14 and say, you know, I think I'm
15 depressed or I< need help↓
16 I: mm hmmm
17 P8: And they won't say specifically
18 <I want drugs>
19 I: Right
20 P8: But the:n you tease out↓ and (1)
21 you know what (1) I was telling
22 XXX I very much (just) listen to
23 what my patients are saying and I
24 don't say you need↑ drugs, you know
25 (1.5) if they say, we:ll↓- I say you
26 know what kind of help do you want?
27 (.) I don't kno::w↓ what's: (1)
28 [the:re]
29 I: [right]
30 P8: or what's available I'll say
31 well: we treat with (1) counselling

32 or this that and the other depending
 33 on (.5) what the situation is for
 34 that pa↑tient↓ (2) and °then you°
 35 kind of let them decide.
 36 I: mkay
 37 P8: There's some people who >totally
 38 will not take chemicals-<
 39 I: ah: yes
 40 P8: and there's some people who will
 41 go to pills first [and]
 42 I: [hah hah]
 43 P8: don't want to talk about
 44 anything so it's very [much]a: (.5)
 45 I: [Right]
 46 P: kind of tailor your management
 47 based on what (.5) the person wants
 48 and as long as it's safe and I can
 49 kind of (.) a:gree with it.

Following this physician's initial agreement and the interviewer's confirmation that the physician does indeed encounter patients who make direct requests for medication (ll. 4-6), she went on to discuss more subtle approaches that patients might use to hint at a request for antidepressants, weaving talk of patient autonomy alongside more subtle and contrasting talk that frames the physician as the ultimate decider.

Through the physician's depiction of having used a Socratic questioning technique, this physician provided an account of exploring patients' subtle queries and offering them options for treatment, allowing the patients to arrive at the treatment approach. Though the patients' inquiries were constructed as a subtle request for an antidepressant, this physician indicated that she would initially refrain from recommending medication ("I don't say you need↑ drugs"; ll.

23-24). One interpretation of this account is that she was describing herself as avoiding any presumption of the patients' intent and also avoiding positioning herself as one who takes control of the treatment process. However, when describing how she presents the available options for treatment, counselling was listed and other options were left unspecified. This physician's account of describing specific treatment options and inviting the patient to choose implies that she has a significant role in shaping treatment decisions.

This physician alluded to describing what might be multiple other treatment options in an informal and indirect manner by saying "this that and the other" (l. 32); however, the ensuing dichotomy that seemed to be constructed (between those who refuse to take medication for depression and those who refuse to participate in psychotherapy) suggested that the options were actually limited to only two approaches. The patient's role as the treatment decider was emphasized by the physician's description of asking a patient "what kind of help do you want?" (l.26). However, she ultimately seemed to describe the patient's role as restricted in its scope through the use of the limiter 'kind of' ("and °then you° kind of let them decide"; ll. 35).

This construction of the patient as a limited decision maker was further elaborated by the physician's suggestion that her treatment approach is tailored to the patient's preference for medication or counselling but also restricted through the use of the important caveat that it must be safe and the physician must agree with it (ll. 48-49). Thus, within a broad account of shared decision-making, this physician described maintaining a predominant role by determining which treatments will be offered, featuring certain treatment approaches over others, and having the 'final word' on the treatment decision.

In the following extract, we explore a very brief exchange with a physician who similarly claims the final word while presenting his approach as patient-centered.

Extract 2.

1 I: And so what (.) what sort of
2 (.hhh) (.) phrase would you use to
3 describe your role? (.hhh)
4 ((clears throat))
5 P9: Well (1) >I problem solve< (1.5)
6 I'm a problem solver.
7 I: Yeah
8 P9: And uh: (.) I'm a giver of
9 information↑ (.5) um my very very
10 bes:t (1) <uh:: (.) um:> viewpoint
11 and opinion.
12 I: °okay°
13 P9: And then they decide (1) if they
14 think (.5) they want me to help
15 solve their problem (.) and if they
16 agree with my view↑point
17 I: °yeah, yeah°
18 P9: it's pretty simple
19 I: °yeah:°
20 P9: really it's not (.5) rocket
21 science [hah hah]
22 I: [hah hah] okay

This physician's description of his own role in patient care provides an interesting weaving of talk emphasizing the physician as the decision maker alongside opposing talk of the patient as the decider. The initial response to the question ("Well (1) >I problem solve< (1.5) I'm a problem solver"; ll. 5-6) could be considered to be a construction of a heavy-handed or controlling approach to patient care; however, it is followed by contrasting talk of "viewpoint and opinion" (ll. 10-11) which suggests an emphasis on the patient as the decision maker. This

mid-utterance change can perhaps be considered as an attempt by the physician to guard against a possible presentation as controlling and domineering.

Although this physician is asked to describe his own role in the treatment process, he provided clues about how he constructs the role of his patients as well. For instance, a patient's actions ("they decide"; ll. 13) are certainly not discounted, though the physician's own contribution was heavily emphasized and appears predominant when he states, "they decide (1) if they think (.5) they want me to help solve their problem (.) and if they agree with my view↑point" (ll. 13-16). This physician's approach frames the patient as the one making the decision, though the necessity of the physician's involvement is unmistakable. The patient's role can be ultimately read as 'limited decision maker' and appears to be restricted to whether or not s/he agrees with the physician's viewpoint and approach to treatment.

The final statement ("it's not (.5) rocket science"; ll. 20-21) is hyperbole, though its function is not immediately apparent. It might serve as an attempt by the physician to communicate to the interviewer the 'taken-for-grantedness' of his approach to treatment, as is suggested by the utterance "it's pretty simple" (l. 18) which preceded it. Alternatively, the statement, "it's not (.5) rocket science" (ll. 20-21) might have been in reference to the physician's role and what he contributes to the treatment process, thus serving to further emphasize the patient's role and minimize his own.

The following extract provides a final example of a physician who is significantly involved in the process, yet presents the patient as in control of the treatment decision.

Extract 3.

1 I: So in these instances when you're
2 kind of: (2) >it sounds (try- you
3 know) trying to< give a (.5) bigger

4 context for this individual >you
 5 know maybe they- they< want an
 6 antidepressant yeah maybe↑ they need
 7 one but maybe: (.hhh) (.5) you know
 8 >maybe it's kind of< more normal (.)
 9 mood, maybe it's: an external event,
 10 maybe it's (.) lifestyle >all these
 11 things you're describing< (.) um are
 12 they open to those kind of discuss-
 13 like >you know< thi- this discussion
 14 away from antidepressants? If
 15 they're making (.) you know, a
 16 request for them?
 17 P10: It's not a common discussion
 18 really if someone's: (.) wanting it
 19 unless unless >we kind of go through
 20 that and they go< ↑oh:: I thought
 21 that was depression then (.hhh) (.5)
 22 you know >I- I wouldn't [say]<
 23 I: [I see]
 24 P10: >I wouldn't talk them out of
 25 [treatment]<
 26 I: [I see]
 27 P10: like it would just be maybe not
 28 medicine at this stage maybe try
 29 counselling first and we'll <meet
 30 again> after you've (.5) been there
 31 for a month or so and (.hhh) (.5)
 32 and re-assess or see what the
 33 counselor says, see if you can do
 34 the exercises (.hhh) (.5) if you
 35 can↓'t then you probably need the
 36 medications then but (.hhh) (1) the

37 >majority of the time if someone
38 really wants to go< with an
39 antidepressant I'm (.) I'm pretty
40 good with that like as long as
41 [they're]
42 I: [I see]
43 P10: looking at some other things
44 too like that it's not the [only]
45 I: [right right]
46 P10: (.5) treatme↑nt.

This extract followed from a conversation about hypothesized causes of depression or low mood that would not necessarily warrant treatment with antidepressant medication and might have instead prompted a discussion about lifestyle changes or other non-pharmaceutical treatments, such as counselling. This physician's account varied between describing her approach as typically deferring to the patient by endorsing most requests for medication and, conversely, describing a process of redirecting patients toward non-pharmaceutical approaches to treatment when it seems appropriate to do so. For example, though she previously highlighted the contentious nature of prescribing in certain circumstances, this physician initially framed these situations as infrequent, implying that a request for medication would typically be appropriate or at least likely to be endorsed. She followed by suggesting that some form of treatment would be offered in such cases where medication was not appropriate (ll. 24-25) and provided an account of an approach to temporarily deny antidepressant treatment that she felt was inappropriate ("it would just be maybe not medicine at this stage"; ll. 27-28). Medication was then characterized as an appropriate approach to treatment when counselling is ineffective, though again this physician reiterated that she was willing to prescribe antidepressants if this is

the patient's treatment of choice. Finally, she suggested that the patient must also be "looking at some other things" (l. 43) in order to be prescribed antidepressants.

By suggesting that antidepressant medication is offered when it is the patient's preferred treatment approach, this physician framed herself as 'patient-centered,' encouraging of autonomy, and generally deferring to patient wishes with regard to pharmaceutical treatment. At the same time she presented herself as invested in compelling patients to attempt other treatments first, such as counselling. As well, she alluded to her own requirement that patients participate in other approaches to treatment alongside antidepressant treatment. One potential result of this physician's requirements is the limiting of the patient's ability to make autonomous treatment decisions.

Determining (In)appropriateness

In this section, physicians' accounts of refusing requests for antidepressant medication are explored. Through their talk of using persuasive techniques, physicians framed their practice as a balance between attempting to offer appropriate care while at the same time attempting to maintain their relationship with the patient who has requested antidepressant medication. These extracts highlight a central challenge to this balance: the potential for the physician - patient relationship to be framed as breaking down if decisions are not perceived as jointly agreed on.

Extract 4.

1 I: Okay (.hhh) (1) um: (.) so how-
2 how do you approach those
3 situations? It sounds like they're
4 <fairly rare> but (.hhh) (.) um >so-
5 so the< situations where somebody
6 would °come in and° (1) make a
7 request obviously it's different
8 depending on whether they've been on

9 it before or not (.hhh)
 10 P11: mhhh↑ (3) well you kind of (.)
 11 go back to step one and yo:u (.)
 12 say:(1) why↑ and often they're
 13 volunteer↑ring that information
 14 I: °yep (.) yep°
 15 P11: but then you explore it a
 16 little bit (.) fur↓ther to (.) see
 17 you know (.) do they: (.hhh) (1.5)
 18 do they truly have a diagnosis <of
 19 depression↑>
 20 I: °okay°
 21 P11: um or something that would (.)
 22 benefit from-
 23 I: °mhhh°
 24 P11: from that (1) um: (.hhh) (1.5)
 25 an:d sometimes <too you go back to
 26 the risk- the risk benefit thing>
 27 (.hhh)(.5) um:: and (.) if what
 28 they're <requesting:> (1) is a trial
 29 of the:: medication that: (1.5) you
 30 know with their history: (.) is
 31 probably not gonna (.5) be too
 32 harmful and they- and there might be
 33 some benefit
 34 I: °yep°
 35 P11: often I'll I'll let them try it
 36 I: °okay°
 37 P11: that's not the case for some of
 38 the other medications like if the:
 39 (.) you know >controlled substances
 40 and that kind of thing<
 41 I: °mhhmmhmm°

42 P11: But um: (2)
 43 I: So you'd say there's less risk
 44 with the antidepressants than-
 45 (.hhh)
 46 P11: Well depending on which one
 47 [you choose]
 48 I: [°you choose] yeah°
 49 P11: yeah but there are some pretty
 50 darn:(.) there's some pretty saf:e↑
 51 (.) safe ones out there that (.)
 52 don't have a lot of (.hhh) (1.5)
 53 risk and when <they're used (.)
 54 correctly> (2) [so]
 55 I: [(okay)]
 56 P11: So- so it is if- if the patient
 57 feels really strongly and if- if I
 58 agree that there- there <may be>
 59 some benefit to it↑ (.hhh) (.5)
 60 then (.) yeah (.) I'll- but >if
 61 it's- if it's< no↓t if it's mo:r:↓e
 62 (2) if I- if I go into the: (.)
 63 history an:d think (1.5) that um:
 64 (1) that there- there's really no
 65 (1.5) history for::depression
 66 (.hhh) (1) um::: really (2) couldn't
 67 see any real (.) benefit (.5) then
 68 I:'ll: (1.5) °then I won't prescribe
 69 it° (.) uh but I- I usually heh try
 70 and (.hhh) (.5) do it in a way that
 71 they're the ones that (.) decide
 72 that (.) [hehhehhehheh]
 73 I: [°hehhehhehheh°]
 74 P11: and not not and, and certainly

75 not [manipulative you know]
 76 I: [yeah yeah (.) y[↑]eah]
 77 P11: because in the end if I really
 78 feel (.hhh) (.5) that this is: (.)
 79 gonna cause you more harm than go[↑]od
 80 [I won't do it]
 81 I: [yeah (.) yeah right]
 82 P11: but (.5) hopef- usually you can
 83 convince them of that too
 84 I: So that it's sort of [their]
 85 P11: [So] that
 86 they at- at the very least they
 87 accept that.
 88 I: [yep exactly]
 89 P11: [yep]
 90 I: °makes sense° [hehhehheh]
 91 P11: [hehhehheh]
 92 cause they'll just go down the
 93 street to the mediclinic and ask for
 94 it from someone else[↑] if they don't-
 95 (1.5) that's what happens hehhehheh

In responding to the interviewer's question, this physician provided an example of how she might typically approach treatment planning with patients who request antidepressants. Following the patient's volunteering of information, the physician accounted for some of the factors that influence her decision to either endorse the request or deny it. These factors can be considered rules of thumb or guidelines and are interesting in their varied levels of specificity. For instance, this physician referenced the precise, "diagnosis <of depression[↑]>" (ll. 18-19) as well as the comparatively more vague, "something that would (.) benefit from- . . . from that" (ll. 21-24) as examples of two such guidelines. She elaborated slightly on the latter statement by

invoking a risk-benefit approach, which is a hallmark of physician problem solving. In this case, the statements “probably not gonna (0.5) be too harmful” (l. 31-32) versus “might be some benefit” (ll. 32-33) might not seem like a reasonable balance when determining a given course of action; however, antidepressants are being considered in the context of opioids or other drugs that are notorious for their negative side effects, risk of abuse, and potential for dependency.

This physician also constructed how she proceeds when these guidelines are presumably not met. For instance, she provided an account of using a subtle persuasive approach that involves exploring the request from the patient’s point of view, in order to involve the patient in the process and eventually bring the person around to the conclusion that antidepressants are not an appropriate treatment (ll. 69-72). In a likely attempt to counter what might be a negative conceptualization of such an approach, she denied that this is a “manipulative” (l. 75) act, and fell back on the balance of risks versus benefits. This physician suggested that, by involving the patient in the process of refusal, potential conflicts can be avoided. At risk to this process would seem to be the realistic possibility that the patient can simply attend another physician’s office if he or she does not like what he or she hears (ll. 92-95).

In the following extract, the physician went even further in suggesting that patients might actually benefit from having their request refused in a careful way.

Extract 5.

1 I: . . . and so:: (1) I guess how-
2 how do you come to that you know
3 that you agree with it um (1.5) >I
4 guess I’m kind of interested in:<
5 you know (.) wha- what do you do if
6 a patient (.) makes that direct
7 request aside from °uh° kind of
8 laying down some different °options°

9 P8: You mean they: (1)
 10 >specifically< requesting [a]
 11 I: [Yeah↑]
 12 P8: [medication?]
 13 I: [yeah↑] you know I want a- (.) °I
 14 want an antidepressant°
 15 P8: mkay
 16 I: how do you address those (.5)
 17 [those questions]
 18 P8: [well I first] make sure they're
 19 depre:ssed and the:y meet the
 20 criteria for an [antidepressan↑t]
 21 I: [°mhmhmmhmm°]
 22 P8: u::m: sometimes (1) I get that
 23 request and it's quite obvious that
 24 there's a: <situation at wor:k or at
 25 ho:me>
 26 I: °right°
 27 P8: that's a stressor
 28 I: yes
 29 P8: a::nd↓ then I'll say you know >I
 30 really don't think< pills are gonna
 31 (.) fix this
 32 I: °mm°
 33 P8: (2) a::nd kind of (.) lean them
 34 towards- kind of >give them
 35 information< about (.5) you know til
 36 you: remove yourself from that
 37 situa↑tion
 38 I: °mm°
 39 P8: and modify that situation (.) no
 40 amount of pills is gonna (.) fix
 41 [it]

42 I: [°mhmm°]
 43 P8: And sometimes when: (.5) someone
 44 from (1) a different perspective
 45 will tell them that↑ (1) they can
 46 see: ↑it↑ (.5)
 47 I: °hmm°
 48 P8: but they couldn't actually see
 49 getting out of it (at times) and
 50 sometimes it's time off wor:k↑
 51 I: [°yes°]
 52 P8: [this and that] so:: (1.5) u:m
 53 but sometimes when they say they
 54 want pills I agree it's the right
 55 medica- right choice [so:]
 56 I: [°mm°]
 57 P8: we'll go with that.

This physician was quite direct and succinct in describing her own guidelines for assessing the appropriateness of her patients' requests for antidepressants, and drew on strategies that varied in their level of specificity. For instance, although ensuring that the person is depressed (ll. 18-19) could be considered a highly precise guideline, it is unclear what the "criteria for an [antidepressan↑t]" (ll. 19-20) might include. This physician did offer a telling example of her own definition of an inappropriate request (ll. 22-25), perhaps as a way of expounding on the previously mentioned criteria for an antidepressant. She provided an example of what can be considered a situational depression and suggested that medication is inappropriate for depression resulting from problems associated with difficult life circumstances (ll. 29-31).

In the case of depression that appears to be associated with problems of everyday living, this physician provided a prototypical exchange that suggests how she might refuse such a request. She began with a rather direct statement about the inappropriateness of the requested

medication (ll. 29-31) before enacting a more delicate approach through the statement, “a::nd kind of (.) lean them towards-” (ll. 33-34) to possibly convince the patient of her way of understanding the issue and its treatment. This shift involved an explanation and a dialogue about the issues and suggests a careful approach to refusal is promoted by this interviewee. This physician did not complete her statement about ‘leaning’ the patient in a certain direction and instead shifted her wording mid-sentence (“kind of (.) lean them towards- kind of >give them information<”; ll. 33-35). The change from an utterance related to patient guidance and control to one that more strongly alludes to patient autonomy was possibly done to avoid or redress the connotation of coercion or manipulation that the former statement might have implied.

This physician suggested that it can be helpful for some patients to be denied their requests for antidepressants and to be offered an explanation (ll. 43-49), and yet her depiction of using subtle and persuasive language to convince patients of her approach suggests that there is some concern about the possible consequences of refusing the request outright. This notion is further explored in the following extract when the physician presented a circumstance in which the provision of an explanation is not ‘enough’ and the patient was framed as insisting that his or her request for antidepressant medication be fulfilled.

Extract 6.

1 P1: If they're new patients <I tell
 2 them to try other alternative things
 3 there> (.) whether uh::: (.) like I-
 4 then (.) I ask them what their pro-
 5 like, okay >let's deal with it. This
 6 is what your diagnosis is< but this
 7 diagnosis could be (.) based-
 8 related to something else so you
 9 must treat the underlying pro:blem

10 (.) don't, don't treat a depression
11 (.5) always with the drugs there
12 (.5) and that's important to know
13 (.5) that if you're having pai↑n and
14 if you're not solving your pai↑n
15 problem (.) taking antidepressants
16 is not going to help you
17 I: °mhmm°
18 P1: or if your u:h problem is (.) uh
19 your social situation, your
20 financial situation (1) it's not
21 going to help you- I try to
22 discourage them
23 I: [°right°]
24 P1: [But] if they still insi:st (.5)
25 I tell↑- as I said (.5) I would be
26 liberal. It's not like that
27 (antivirus) will do any harm to
28 them
29 I: °mhmm°
30 P1: or uh:↓ (.5) taking some pill
31 that's going to be (.) hurting them
32 (.) taking a- take antidepressant
33 but they↑ have (1.5) (hhh) (2)
34 humans are not meant for taking
35 medicine, I think we've been kind of
36 forced to (.5) take them, these
37 medication. Nobody likes medication
38 >so I think I'd leave- give the
39 judgment to the patient as well<
40 I: I see
41 P1: And plus↑ I (.5) do decide if it
42 is reasonable

43 I: Right
44 P1: if it is a- within reasonable
45 limits I will prescribe it, if it's
46 not reasonable I will tell them that
47 it's not a good idea to take these
48 drugs . . .

In this example the interviewer has asked the physician to respond to a difficult clinical circumstance: a patient requesting antidepressant medication that the physician does not believe is warranted. In this physician's presentation and explanation of the process he uses to attempt to discourage an inappropriate request, it is apparent that he is not always successful. In stating that he would explain "alternative things" (l. 2), he was presumably referring to alternative treatments, though they are not defined. Similar to the previous extract, he drew on problems of everyday living (using the example of pain, as well as social and financial burdens; ll. 13-21) to present examples of issues that antidepressants would be inappropriate to treat.

By describing himself as one who gathers information and attempts to discourage inappropriate antidepressant use, he positioned himself as taking a careful approach to refusal (ll. 12-22). In contrast to the other extracts that depict physicians framing themselves as resolute in this refusal, this physician acknowledged that he accedes to the request when his patients "still insist" (l. 24). Perhaps in an attempt to justify this seemingly contradictory position, he drew on the balance of risk versus benefit by suggesting that although the benefit might be low in such circumstances, the risk of harm is even lower (ll. 26-31).

In the context of acknowledging that he prescribes antidepressants when he does not believe they are indicated, this physician risks being characterized as having weak professional boundaries, and as contributing little to the decision-making process. Perhaps to guard against

this possible characterization, he highlighted the importance of patient contribution and choice in the process by replacing “leave-” with “give” (l. 38). To ‘leave judgment’ has the potential to suggest an abdication of responsibility, whereas to ‘give judgment’ implies a choice and recognition of the patient’s ability to take on this responsibility. Through this mid-utterance shift, this physician effectively positioned himself as supportive of patient involvement and autonomy. Unlike other extracts that frame physicians as guarding against conceptualizations of being overly paternalistic and controlling, this physician guarded against the contrasting role of under-involvement, though he did so in a similar manner by appealing to the notion of patient autonomy.

Discussion

Research supports the notion that patients’ requests for specialist referrals, diagnostic tests, and treatments are routine in the examination room (Kravitz et al., 2003; Toiviainen et al., 2005). Most physicians interviewed for this research indicated that patients’ requests for antidepressants are quite common, and few constructed such requests as rare or problematic, even when they felt that the request was inappropriate. Several extracts in the present article show how these physicians spontaneously constructed a dialogue between themselves and what seems to be a prototypical patient, suggesting that such interactions are common enough to develop stock phrases and routine approaches to patient requests. These accounts were typically marked by ease and informality of language, further suggesting that these instances are not uncommon. In the context of the broad shift from a paternalistic model toward models that feature more equal involvement from patients and physicians, it is perhaps no surprise that physicians depicted patient requests as common and unproblematic.

One way these physicians framed their response to patient requests for antidepressants and constructed their involvement in the treatment process was by depicting a carefully defined

option set within which the patient is characterized as ‘free’ to make the final treatment decision. In the first set of extracts, the physicians minimized their own role in the process and ostensibly framed the patient as the ultimate decider. It is evident, however, that although the patient is framed as the agent in the process, it is really a ‘limited decision maker’ role. These physicians constructed accounts of themselves acting in a manner that ensures their contribution to this process does not become diluted to that of what one physician (whose excerpts were not featured) presented as “just the technician to write the prescription.” In other words, these physicians provided accounts of working within a joint approach to treatment decision-making, but reserved the right to the ‘final say’ on antidepressant treatment, suggesting that they are keenly aware of their own responsibility for the treatment their patients take up.

Antidepressants were frequently included in the option set constructed by physicians, a likely testament to the popular notion that antidepressants are considered a medically ‘reasonable’ treatment approach for depression. It is useful to consider how physicians might interpret a patient request for a less reasonable (or for that matter, less medical) treatment option. One wonders how the physician-defined parameters of autonomy proposed here might differ in such circumstances (e.g., the option set provided might well shrink further, or not ultimately include these requests and might include others instead). This raises an important yet controversial question: should antidepressants be considered a reasonable approach to treatment for most depressed patients?’ The efficacy literature suggests that antidepressants are a questionable approach to treating transient, mild, or even moderate depression, yet many physicians continue to prescribe them in these instances (Fournier et al., 2010; Kirsch et al., 2008; Middleton et al., 2011). Though many of the physicians we interviewed were wary of treating problems of everyday living with medication, others constructed accounts of giving into patient requests or otherwise falling back on the low risk associated with these medications. It is

of note that physician interviewees did not construct accounts of being more generally critical of antidepressant medication as an effective treatment for depression. The question of whether a given illness experience should be considered within the physician's domain has long been one of significance for family physicians (Toon, 1999 as cited in Murray et al., 2006). Research suggests that physicians might find themselves increasingly challenged by patient requests for clinical services (Kravitz et al., 2003; Toiviainen, Vuorenkoski, & Hemminki, 2005). Some of these requests may be treatments that further buttress the biomedical conceptualization of depression, despite this particular treatment option being quite limited in its effectiveness, and possibly inappropriate.

Presently, management of medical resources and triaging access to diagnostic tests, treatments, and referrals to specialists remains an important aspect of a physician's role and responsibilities. This gatekeeper role has always been particularly important within the Canadian context because ours is a medical system financed almost exclusively by taxpayer-funded transfers from the federal government. The way in which physician interviewees accounted for refusals of inappropriate requests for antidepressants is also of particular relevance in the context of controversy regarding the efficacy of antidepressants and increasing concerns about the utility of treating problems of everyday living with pharmaceuticals. The gatekeeper role is thus as relevant and necessary as it ever was, though it is potentially challenged in the context of treatment decision-making that has shifted increasingly toward an approach that supports the patient's interests which, at times, are inevitably going to vary in compatibility with the physician's gatekeeper mandate. Indeed, attempting to navigate treatment decisions and patient requests without flexibility and carefully implemented approaches to refusal could be potentially disastrous. On this point, Paterniti et al. (2010) argued that patient requests for clinical services

will occasionally result in the need for persuasion, explanation, and justification of the refusal, if relationships between patients and physicians are to be maintained.

There is significant controversy in the literature regarding whether or not persuasion can or should occur within joint approaches to treatment decision-making. For instance, Karnieli-Miller and Eisikovits (2009), in their study of gastroenterologists, suggested that shared decision-making was a philosophical tenet held by the physicians they studied, but concluded that it seldom occurred in practice. Rather, they argued that physicians were making unilateral decisions and using persuasion and coercion to bring the patient alongside their position. In contrast, Eggly (2009), in critiquing Karnieli-Miller and Eisikovits's (2009) conclusion, argued that persuasion should not be considered inherently coercive. They emphasized the normality of people in everyday situations attempting to convince through reasoned argument, and suggested that joint decisions can ultimately be made within a persuasive environment. Likewise, physicians in the present study provided accounts of encouraging patients to determine their own treatment within strictly defined parameters, and generally insisted on agreeing with their patient's requested treatments. These positions are not necessarily inconsistent with a jointly determined approach to treatment. Assuming that patient requests for antidepressants themselves are considered to be persuasive actions, these physicians presented themselves as using a similar approach in order to claim their own involvement in the process.

Concluding Remarks

Physicians working within a primary care system that increasingly emphasizes patient choice and autonomy while at the same time requires that physicians act as stewards of limited resources face challenges in reconciling these aims. The physicians in the present study claimed to work within what can be considered a joint approach to treatment decision-making by balancing opportunities to encourage patient autonomy while at the same time maintaining

considerable involvement in the process. When patient requests were determined to be outside these limits, they constructed accounts of managing requests through acts of persuasion that involved an exploration of the context of the request and communication of the rationale for why medication was not appropriate.

Study Limitations and Directions for Future Research

One of the primary limitations of this research relates to the sample of participants that was chosen. It is likely that the physicians who responded to our request for study participation held a particular interest in the topic of depression. Indeed, several of the participants disclosed that they had an interest in treatment for depression and mental health issues in general. Their conversations about the topic might have been quite different from those of other family physicians who face similar challenges in their treatment of depression, though are perhaps less invested in this topic area. A somewhat broader recruitment of physician interviewees with more varied levels of interest and experience in mental health will be important for future research.

Another important direction for future research involves further exploration as to whether depression reasonably constitutes a problem that falls within the purview of the family physician. This area of inquiry is particularly important in the changing landscape of primary care. One approach might be to explore and identify the role(s) that physicians must continue taking up, and those that can or should be performed by others (either professionally or personally).

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Study 2: Patient Accounts of Requests for Antidepressants: Persuasive Presentations and
Unexpected Outcomes
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Abstract

Prevailing models of primary care treatment decision-making have changed drastically from those that frame physicians as primary decision makers to those that feature patients as more autonomous deciders. Existing somewhere in the centre of the treatment continuum are joint approaches to treatment decision-making. One example of this changing model of Western health care is the patient request for clinical services. I interviewed 11 patients about their experiences requesting antidepressants from their physicians. Using a discursive analytic approach, I argue that (a) patients employ a ‘soft sell’ approach in arguing for the appropriateness of antidepressants, while framing their physician’s contribution to decision-making as necessary and important, and (b) unexpected (and unpleasant) outcomes that follow requests for antidepressants can be understood as discrepancies between the patients’ preferred level of physician involvement and what they encountered. These actions are discussed in the context of a changing model of health care and the potential for conflict to develop when treatment decisions are negotiated.

Study 2: Patient Accounts of Requests for Antidepressants: Persuasive Presentations and Unexpected Outcomes

Depression is common in North America (Patten et al., 2006) and its management overwhelmingly takes place by a family physician (or general practitioner; GP) in primary care situated within the medical model (Mitchell, Vaze, & Rao, 2009). While social workers, psychologists, and psychiatrists are typically assumed to be the principal mental health workers, as many as 70% of individuals who visit their family physician report depressive symptoms (Robinson, Geske, Prest, & Barnacle, 2005). Furthermore, physicians report that depression is the second most common condition they encounter in primary care, after hypertension (Lewis, 2001).

Primary care treatment for depression in North America typically proceeds with one of three approaches: antidepressant medication, psychotherapy, or some combination of these two options (Trangle et al., 2012). Antidepressants appear to be the treatment of choice for many physicians. In Canada, 4.7% of those aged 15 years of age and older are taking an antidepressant, representing nearly one and a half million Canadians (Beck et al., 2005). In America, antidepressant use amongst all ages increased nearly 400% between 1988 and 2008 and more than one in ten Americans age 12 and over were taking antidepressants between 2005 and 2008 (Pratt, Brody, & Gu, 2011). Unfortunately, the options family physicians have in treating depression in primary care are quite limited and the utility of antidepressants is certainly in dispute. For instance, it has been suggested that antidepressants are effective in treating only severe depression (Fournier et al., 2010; Kirsch et al., 2008) and there are significant doubts about whether these effects are clinically meaningful (Moncrieff & Cohen, 2006). It is perhaps for this reason that discontinuation rates are exceedingly high, with as many as 55% of patients discontinuing antidepressants within the first 3 months, and 70% discontinuing within 6 months

(Monfared, Han, Sheehy, Bexton, & LeLorier, 2006). Despite questions about the efficacy of antidepressants, a recent review of GPs' management of depression in primary care suggested that most physicians continue to regard antidepressant medication as the standard in their treatment of depression either because antidepressants are seen as the most helpful available intervention or because of a perception that there are limited other options for managing depression (McPherson & Armstrong, 2012).

Changing Models of Healthcare

The traditional approach to treatment delivery in Western health care involved the physician as the dominant decision maker and the patient as the passive treatment recipient. This traditional model was a top-down, expert-driven approach to treatment built on assumptions that a single best treatment existed, that physicians were informed about this best treatment, and that they were ethically bound to implement it (Charles, Gafni, & Whelan, 1999). Quill and Brody (1996) provided an excellent summary of how the consumer rights and patient rights movements of the late twentieth century, in combination with broad concern about rising healthcare costs and the legislation of informed consent, have shifted momentum away from the physician as the treatment decision maker (a paternalistic model) and toward the patient as the decision maker (a patient-directed model). In the centre of this continuum lie various joint approaches to treatment decision-making that generally require agreement between the patient and the physician. The most popular of these treatment approaches is what Charles, Gafni, and Whelan (1997) titled 'shared decision-making.' Despite that shared decision-making has been heralded as a paradigm shift in primary care (Coulter, 1997), it is not always implemented in physicians' day-to-day practice (Karnieli-Miller & Eisikovits, 2009; Légaré, Stacey, & Forest, 2007; Stevenson, Barry, Britten, Barber, & Bradley, 2000).

Patient Requests for Clinical Services

Patient requests for referrals for diagnostic testing, specialist appointments, and medical treatments (including prescription medications) are relatively recent phenomena that, by definition, are largely incompatible with a paternalistic approach to treatment decision-making. Instead, patient requests usually occur within a treatment decision-making process characterized by the autonomy of the patient-directed approach or the collaboration of a joint approach. Patient requests for such services are also commonplace, with requests for clinical services estimated to occur in between 10% to 25% of primary care visits (Kravitz et al., 2003; Toiviainen, Vuorenkoski, & Hemminki, 2005).

Research largely supports the notion that if patients ask for antidepressants, they are likely to receive them regardless of whether their presentation would seem to warrant this medication (Kravitz et al., 2005; Mintzes et al., 2003). This practice has fueled an argument that physicians too easily acquiesce to patient requests regardless of whether there is a clinical need for the requested treatment. In their important contribution to this controversial finding, Epstein et al. (2007) concluded that antidepressant prescriptions were driven almost entirely by patient request, and not clinical presentation, when medical visits were characterized by low levels of exploration and validation of patient concerns by physicians. Conversely, the authors concluded that antidepressants were more likely to be prescribed appropriately (i.e., based on clinical presentation) when visits between patients and physicians were characterized by high levels of exploration and validation of patient concerns. These findings certainly suggest that patients can influence physicians' prescribing actions through their requests, for better or for worse.

There are ways to explain why one physician might simply endorse a patient's request for antidepressants while another explores the request more fully which go beyond relying on explanations that rely solely on individual differences in diagnostic and treatment practices

amongst physicians. One possibility is that physicians attempt to match their treatment decision-making approach with one they assume their patients prefer. For instance, requests for antidepressants from patients that physicians assume are enacting a more autonomous patient-directed approach might be granted easily, while a more thorough exploration of the issues might be enacted with those patients who are assumed to prefer a joint approach to treatment decision-making. Unfortunately, making a determination about the level of involvement a given patient prefers is evidently not a straightforward task. One research study has suggested that physicians overestimate or underestimate the level of involvement their patients want in as many as 68% of cases (Cox, Britten, Hooper, & White, 2007).

Another possibility is that some physicians might be hesitant to refuse requests for what are commonly considered relatively safe medications (such as antidepressants) in order to preserve their relationship with their patients. This is of particular relevance as patients can quite easily request antidepressants from another physician if their requests are denied. This possibility, though little researched, does appear to have some support; findings by Bell, Wilkes, and Kravitz (1999) concluded that nearly half of their sample of laypeople would be disappointed if physicians refused their request for a specific drug. Of those disappointed, 25% indicated that they would go so far as to ‘shop around’ or try to persuade their physician otherwise, and 15% suggested that they would actually terminate the relationship with their doctor. These findings certainly suggest that a good number of patients would seem to prioritize their request for medication over their physician’s contribution to the decision-making process.

Much of the research on patient requests for antidepressants, including those studies that have been presented here, focus largely on whether and how requests for antidepressants are likely to be endorsed, and how patients might respond to refusals of their requests. These findings are certainly interesting, but they offer little with regard to understanding approaches

patients might use to make requests for antidepressants. In the current research I seek to contribute to the literature by examining how patients talk about their requests for antidepressants, how they account for their role in the treatment decision in relation to that of their physician, and how they frame the prescription endorsements or denials that result from these requests.

Epistemology and Methodology

This research was undertaken using discourse analysis within a constructionist epistemology. In keeping with this epistemological stance, I assumed that knowledge is co-generated between people (and not through objective discovery); categories, concepts, and ideas are produced through the use of language; language, in turn, constitutes action; and the knowledge created from this research is specific to the social context, time, and culture in which it was generated (Burr, 1995).

Discourse analysis is a methodology directed toward the study of how language is used to describe things and how it performs actions (Burr, 1995). For instance, the language used to request clinical services both describes such instances, and is also instrumental for these actions to take place. The discursive approach I employed consisted of an analysis of the words uttered and the actions and consequences that result from such utterances (see Wood & Kroger, 2000). In the present article, I examined accounts of requests patients made for antidepressant medication from their physicians and how these accounts fit with broader social practices. Accounts represent an appropriate focus for analysis as they are significant mechanisms by which individuals explain their actions and the frequent site of attributions of causality, responsibility, and blame (Orbuch, 1997). Particular focus was directed toward analyzing how patients framed their requests and their physician's responses to these requests, the strategies

they employed in fashioning their accounts, and the implications of these discursive patterns for our understanding of currently accepted models of primary care.

Method

Participants

Recruitment was initiated through an invitation to contact the researchers via posters placed in community halls, grocery stores, pharmacies, and other high traffic private and public establishments in a mid-sized western Canadian city. This poster is included in Appendix F. The poster invited participation in research interviews from individuals who requested antidepressants from their family physician (regardless of whether the physician endorsed the request). Eleven participants (6 men) agreed to participate in semistructured, individual interviews held over the course of several months in 2009. The patient interviewees ranged in age from 20 to 62 years (with a mean age of 37 years).

Procedures

Prior to recruitment, this project was given ethics approval by the Behavioral Research Ethics Board at the University of Saskatchewan. Patient interviewees provided verbal and written consent prior to the interview. They were made aware of the purpose of the research, and were reminded that they were free to rescind consent and participation at any point (the consent form is included in Appendix G). Individual interviews with each of the 11 interviewees were conducted in a quiet interview room. Participants were asked questions about their experience of depression, antidepressants and, in particular, initiating requests for antidepressant medication from their physician. The interviews lasted between 45 minutes and one and a half hours and were audio-recorded using a digital recorder.

A complete list of interview questions is included in Appendix H. The questions that guided the interviews related broadly to how participants came to see a family physician for

depression, how they went about making their request for antidepressants, and what resulted from these requests. Examples of questions included, ‘Did you go to the physician with a specific goal of being prescribed antidepressants? If so, how did you arrive at this goal?’ and ‘How did the physician respond?’ Interviews were transcribed verbatim and efforts were made to remove all identifying information from the transcripts. Interviewees were given an opportunity to add, delete, and modify their written transcripts prior to analysis (the transcript release form is included in Appendix D). Most of the interviewees declined to participate in this ‘transcript release’ procedure though a few did request phrasing changes, and deletions of extraneous vocalizations (e.g., uh, ah).

Analysis began with multiple readings of the transcripts. A narrowing of focus followed, with particular attention on a subsection of extracts relevant to the specific requests for antidepressants, and the interviewee’s accounts of what resulted from these requests. These extracts were analyzed through an iterative process of examining the structure of the interviewees’ accounts of the arguments they used to acquire antidepressants and the ways in which they framed themselves and their physician in their accounts of having made these decisions. Final extract selection was based on relevance to the research questions, relationship with the literature, and fit with other chosen extracts. Jefferson (1984) notation techniques were used to indicate pauses, changes in intonation and volume, and other linguistic features of talk (see Appendix E for a complete listing of transcript notation techniques) I have endeavored to present background context for those extracts where the context is not apparent from the text itself.

Analysis

In the following sections, I explore interviewees’ talk of making requests for antidepressants, and some rather unexpected outcomes that resulted from these requests. In this

initial section, I show how participants construct themselves as employing a ‘soft sell’ approach in arguing for the appropriateness of antidepressants, while framing their physician’s expertise and contribution to decision-making as valuable. These actions amount to a kind of joint approach to decision-making that very much hinges on the physician’s agreement with the patient’s assessment of his or her own situation and what treatment is required. In the following extracts, (I) refers to the interviewer while (Px) refers to the patient interviewee (with ‘x’ used as reference to the participant number).

A Persuasive Presentation of a Treatment Option

Extract 1.

1 I: Right (.) right (.) okay (.5) um:
2 (4) °ok° (3) and so: >so did you
3 have a strategy< going in to↓ talk-
4 >like I mean obviously< you brought
5 those: (.5) those: symptoms that
6 you’d written down those thoughts
7 going through your head (.5) um did
8 you >have an idea< of you know how
9 you might (1) um <°you know° bring
10 ↑up> antidepressants or- or mood
11 stabilizing drugs↑ >or how you
12 [might]<
13 P1: (hhh) [Uh:]
14 I: get the physician to prescribe
15 them or how- how that conversation
16 might go?
17 P1: Not really like I said he’s he’s
18 known me my whole life and he knows
19 my family history so he knows I have
20 that in my family [he knows]
21 I: [Right]

22 P1: that it's pretty predominant
 23 (.hhh) um so my only thought really
 24 behind it was: (.5) <go talk to (.)
 25 my doctor> (2) tell him (.) I've
 26 been feeling crappy (.5) this- these
 27 three pages are how I feel when >I
 28 am< feeling crappy (1) >What can you
 29 do for me<? Do- you're a
 30 professional (.5) do you think it's
 31 depression or:↓ [you know]
 32 I: [right]
 33 P1: do you think (1) because just
 34 from my knowledge like (.5) >I
 35 wouldn't be< the first person to
 36 jump on that occasion.
 37 I: °Mhmm right so he [(knows you're
 38 not)]°
 39 P1: [But yeah] but >he's- but like
 40 he he is the doctor< if he- (.) if
 41 in his professional opinion knowing
 42 me-
 43 I: Yep
 44 P1: knowing what I'm telling him
 45 knowing my family history if he
 46 thinks that I need antidepressants
 47 then °awe↓some° if he thinks that
 48 it's (.) it's not that↑? Then
 49 that's- that's good too. I just
 50 >wanted I wanted< his opinion on it.
 51 [Find out what he wanted].
 52 I: [I see]
 53 P1: What he thought.

Throughout this extract it is apparent that this interviewee has crafted his own position regarding the best diagnosis and treatment, though ultimately privileges the physician's role as the 'expert' who is expected to confirm or deny his theory. This participant framed his account in terms of having little considered any particular strategy to persuade his physician to prescribe antidepressants, aside from presenting his concerns in a seemingly forthright manner. He did not frame his appeal as a direct request for antidepressants but rather presented his approach through the subtle use of what might be considered a stock phrase (“>What can you do for me<?”; ll. 28-29). In his presentation of the issues that have led him to seek out his family doctor, reference to depression was made throughout his talk. This interviewee also framed his physician as likely to agree with his own determination of the issues, by suggesting that his doctor has known him for his entire life, is familiar with his family history of depression, and is aware of the broader predominance of depression in the population (ll. 17-22). Similarly, when describing his presentation of his journal pages that depict how he feels, and by suggesting that he is not “the first person to jump on that occasion” (ll. 35-36), this participant framed depression as the likely explanation for his symptoms, and antidepressants as the most appropriate treatment option. These examples hint at a ‘soft sell’ approach to this interviewee’s request for medication and belie his assertion that he had no strategy for acquiring antidepressants.

Despite the interviewee’s action of incorporating his depression hypothesis into his subtle request, he framed himself as promoting and inviting his physician’s contribution when he referenced the family physician’s title and status (“>he’s- but like he he is the doctor<”; ll. 39-40), when he admitted that he is open to his physician disagreeing that antidepressants are appropriate (“it’s not that↑? Then that’s- that’s good too”; ll. 48-49), and in his acknowledgement of wanting to know how his physician would like to proceed (ll. 49-53). In one sense, the interviewee’s use of the terms ‘doctor’ and ‘professional’ could be read as part of

his ongoing attempt to align the physician with his own presentation of the issues; however, I argue that his use of these terms and the context in which they are constructed suggests instead an acknowledgment of the importance of the privileged role of the physician over and above his own in making appropriate treatment decisions.

In the next extract, the interviewee provided a similar account of constructing her own position regarding the most appropriate diagnosis and treatment, while ultimately privileging her physician's role in the decision-making process.

Extract 2.

1 P2: Yeah (.) and well uh (.5)
2 >initially I just wanted to make
3 sure< the doctor's opinion of
4 whether or not I was depressed
5 whether or not I was anxious (.)
6 matched up with mine↑ even >though I
7 thought I knew< what was wrong with
8 me↑ I always want to check cause I'm
9 (.) not a doctor (hhh) [so]
10 I: [Okay] so
11 even though you kind of (.5)
12 researched on <your ow:n↑> [and]
13 P2 [Oh yeah]
14 I: Sounds like you're pretty savvy
15 when it comes to finding information
16 an:d (.5) stuff like that (.) you
17 know you- you did want kind of a
18 second opinion °[so to speak]°
19 P2: [>Oh yeah absolutely<]
20 yeah: I don't (.) necessarily trust
21 my own opinion on this I just like
22 to (heh heh) have something in mind

23 so >if I am right I can< say okay
 24 good I (.5) I <know about this now>.
 25 I: Okay right (.) um (1) and- and so
 26 just thinking- I guess↓ focusing
 27 more on that second meeting going in
 28 with kind of the intention to: (.)
 29 <to get some> kind of °medication↑°
 30 [you'd say that's true?]
 31 P2: [Right] uh: yeah↑ I think so: >I
 32 was< (.5) well >I wasn't so much
 33 against< the idea, again I wanted to
 34 (.) ask the doctor and see what they
 35 thought about it (.hhh)
 36 I: Right right
 37 P2: So-
 38 I: So kind of going in to <kind of
 39 say we:ll↑ °what do you think°> you
 40 know.
 41 P2: Like initially she- >the- the
 42 first doctor, Dr. XXX< she had
 43 (.) suggested it↑ and I was like
 44 uh:::↓ I don't think so but (.)
 45 later on I- I wasn't against it so I
 46 figured (.) they would- if: (.5)
 47 that one doctor thought that it was
 48 the right thing for me then (.)
 49 maybe another doctor would and then
 50 I would feel better about going on
 51 it and-
 52 I: I see [I see]
 53 P2: [>things along those lines<]
 54 I: So expe:cting it be offered (.5)
 55 because of [what you know]

56 P2: [Well I[↑] brought it up]
 57 I: [you brought it up] okay
 58 P2: [>I brought it up<] but I was
 59 yeah I sort of expected that it was
 60 something that would help me[↑]?
 61 Because it had already been
 62 [suggested (1) so].
 63 I: Right[↓] right[↓] So how did you
 64 bring it up I mean (.) uh: if you
 65 get thinking- maybe the words <that
 66 you might have u:sed> or (1) °or° (2)
 67 kind of what your angle was?
 68 P2: Um[↑]m (1) I[↑]- I- >I think I just
 69 told her what I told you< I said
 70 well >I went- I talked< to Dr.
 71 XXX and she said that maybe I could
 72 do this[↓] and >I wasn't sure about it
 73 at the time< but now I've (.5) now
 74 I'm thinking that maybe it could
 75 help me so (.) what do you think and
 76 (.5) (.hhh) yeah.

This interviewee also ascribed her physician a somewhat privileged decision-making role when she acknowledged the importance of gauging her family physician's position alongside her initial depiction of her own assumptions about what was wrong. Specifically, she emphasized her own position ("even >though I thought I knew< what was wrong with me[↑]"; ll. 6-8) but ultimately acknowledged the physician's contribution by alluding to the difference in their role ("cause I'm (.) not a doctor"; ll. 8-9). This participant presented herself as open to whatever her physician might contribute to the decision-making process when she made reference to not trusting her own opinion (ll. 20-21). She did the same when she initially agreed with the

interviewer that she intended to get a prescription for antidepressants before backing off on this claim (“[Right] uh: yeah↑ I think so: >I was< (.5) well >I wasn’t so much against< the idea; ll. 31-33). However, this interviewee also reaffirmed her own stance by insisting that she “brought it up” (l. 56) when I suggested that she did not make a request.

It is of note that this interviewee provided an account of her most recent request as driven by a previous meeting with a physician who originally suggested antidepressants. This suggestion, which she initially declined, evidently evolved into a treatment option that she became more interested in pursuing, providing further evidence of her privileging of her physician’s role within the treatment decision-making process. Antidepressants, as a previously recommended treatment, become part of the ‘soft sell’ that made up her subtle query about antidepressants. This participant’s request was certainly not framed as a direct inquiry and was instead framed as a presentation of a treatment option. In this account she positioned herself as deferring to her physician(s) with regard to the most appropriate explanation and treatment, while at the same time placing a certain priority on her own assessment of the issues and her requested treatment.

In the following extract, another interviewee similarly depicted himself as deferring to his physician in what is perhaps the starkest example of subtlety in a request for antidepressants.

Extract 3.

1 I: °Okay° (1) u:m (.) and now did
2 you:: I mean you talked to your
3 fiancée (.) antidepressants- going
4 to the physician- >so was that< your
5 goal in seeing the physician was
6 [to get?]
7 P4: [It was] yeah I sort of had that
8 idea in mind when I went in there↓

9 (.5) a:nd I was: (.5) you know (.)
 10 open to >whatever suggestions< he
 11 might have but I figured (.hhh)
 12 I: Right
 13 P4: you know (.) that would probably
 14 be the↓ (1) right direction.
 15 I: Mhmm okay (.) u:m (.) so (.) did
 16 you do anything to kind of go about
 17 achievi:ng (.) that goal? (.) of
 18 getting antidepressants you know
 19 <aski:ng- suggesti:ng> kind of
 20 [(subtly)]
 21 P4: [I did] not specifically ask for
 22 antidepressants actually I figured I
 23 would wait and see what he said
 24 first so I (.5) <pretty much> u:h
 25 gave him the scoop (.5) u:h (.5)
 26 like I did to you just now↑ and then
 27 you know waited to see what he
 28 figured uh and he was actually the
 29 one who suggested u::h trying (.5) a
 30 °medication°.
 31 I: I see >I see< so it ended up
 32 being [a fit↓]
 33 P4: [°Yep°] <ye:s>
 34 I: [In terms of your ideas]
 35 P4: [Yeah].

In this brief exchange, the interviewee provided his account of making the decision to talk to his physician about antidepressants and of his approach to acquiring this medication. Initially he agreed that his goal was to get a prescription for antidepressants (“I sort of had that idea in mind”; ll. 7-8) though he immediately backed off and suggested instead that he was

“open to >whatever suggestions<” (l. 10) his physician might have had before he reaffirmed his initial position that antidepressants would likely be the “right direction” (l. 14). As in the previous extracts, this interviewee provided an account of his own preference regarding his treatment of choice (i.e., antidepressants) though his approach to acquiring antidepressants was more subtle than those previously presented. Rather than introducing antidepressants as a possible treatment option, his strategy was framed as giving his physician “the scoop” (i.e., explaining his symptoms and what led to his current circumstances; l. 25) in the same way that he provided this information to the interviewer in a previous section of the interview. Following his presentation of his symptoms and current circumstances, this participant provided an account of implementing a ‘wait and see’ approach to first allow his physician the opportunity to spontaneously introduce antidepressants as a treatment option (ll. 27-28).

This approach is more in keeping with a traditional patient - physician relationship whereby the physician directs the treatment of the more passive patient. This action (or rather, this lack of an action) can be read as an acknowledgement of the physician’s privileged role in the treatment decision-making process. However, this interviewee’s statement that he would “wait and see what he said first” (ll. 23-24) does imply that if his physician did not offer antidepressants in response to his complaints then he might have suggested them himself, or otherwise enacted some other approach to acquire antidepressants. In any case, this interviewee framed himself as deferring to his physician’s role in the treatment decision-making process by allowing the doctor to take the lead on recommending a treatment, prior to (or instead of) requesting one himself.

Unexpected outcomes of requests for Antidepressants

In the following extracts, I present accounts that offer a different perspective than those presented in the first section. While the majority of patient interviewees reported receiving the

antidepressants they requested in a straightforward way, in this next section I have chosen to focus on patient talk that related to unexpected (and generally unpleasant) outcomes resulting from the interviewees' requests for antidepressants.

Extract 4.

1 P11: So I went (.5) to (.) <thi↑s:
2 GP> (.5) and raised the issue of
3 antidepressants with him.
4 I: °Yea:h okay°
5 P11: U:m (.) in the last few mon↑ths
6 (1) (.hhh) a:nd (1) <i↑n that
7 appointment with him> (.5) because
8 it was a long appointment >I go to
9 see him< at the naturopathic (.5)
10 clinic.
11 I: He's got more time right?
12 P11: Yep and (.) °um° (1) this was
13 (.) a half hour appointment (.5)
14 u:mm (.5) <and I (1) rai:sed (.5)
15 antidepressants with him> (.5) and
16 he: (4) he: (1) <directed the who:le
17 tone> (1) of the session (.5) away:
18 (.5) from (.5) the topic of
19 antidepressant medication. I was
20 just (1) <blown out of the wa↑ter>
21 because (.) I kno:w (.) that I'm
22 (.5) a patient (.5) <who is> very
23 proactive-
24 I: °Yeah it sounds like [it°]
25 P11: [highly]
26 motivated (.5) committed (.5)
27 disciplined (.5) like I'm: one of
28 the best kind of patients <that you

29 can get↑> as a doctor (.5) um
 30 because I don't consider (.) the
 31 doctor to be responsible for my
 32 health I consider (.5) me: to be
 33 responsible for my health.
 34 I: Yeah
 35 P11: Um: and if I have a health
 36 problem that requires a lot of hard
 37 work >I have to do the hard wor↑k<
 38 (1) so I was just- (.5) to me it
 39 was- (.5) it was actually an example
 40 (.5) of (.) this (.5) doctor's (1)
 41 °umm° (1.5) stereotypical (1)
 42 arrogance (1) um (.) lack of
 43 humility (.5) u:mm lack of respect
 44 for me (.) as a human being and a
 45 patient (.) that he would (2) not
 46 only (1.5) °um° (1) not seriously
 47 consi↑der↓ (.5) that option for me
 48 (.)
 49 I: Right
 50 P11: but he wouldn't even discuss
 51 (1) why he wouldn't consider it.

This interviewee's attempt to discuss her desired treatment with her physician clearly resulted in an outcome than she did not expect and did not appreciate. It should be noted that this extract belongs to the only participant in the study who provided an account of being denied a request for an antidepressant. She constructed an account that is neither demanding nor even directly requesting antidepressants, but instead described having introduced them as a possibility for treatment ("I (1) raised (.5) antidepressants with him>"; ll. 14-15). Aside from this statement, she offered few details of just how she approached her request; rather this participant

was oriented toward the seemingly unexpected result of this conversation. As well, she did not provide any account of the particular words or phrases that her physician might have used to deny her request, other than to frame her physician as changing the topic of conversation away from antidepressants (perhaps even deliberately; ll. 16-19).

This interviewee's strong negative reaction to her account of her physician's approach is undeniable and suggests that she is a patient who is clearly displeased that she was not able to be more involved in the decision-making process. She argued that she is a patient that is "[highly] motivated (.5) committed (.5) disciplined" (ll. 25-27) which provides a context for her dissatisfaction with her physician's actions. Her strongly emotive descriptors (e.g., "stereotypical (1) arrogance"; ll. 41-42) bring to mind what could be considered prototypical examples of the worst attributes of a physician practicing within a staunchly paternalistic model of health care. Though she might be perceived as a patient who wants absolute control of the decision-making process at the expense of any contribution her physician might have, her final statement suggested that it is not only the physician's refusal to endorse her request that is so frustrating. It is also the manner in which she was dismissed from the process of treatment decision-making and the denial of an opportunity to discuss the physician's concerns that upsets her (ll. 50-51). This extract provides a distinct contrast to those explored in the previous section. This participant's depiction of her reaction underscores the importance that she places on a balance of involvement between herself and her physician, and also highlights the negative outcome when this position is perceived as being disregarded.

The following extract differs from the previous one, in the sense that it is not the denial of the patient's request and being dismissed from the process of decision-making that is depicted as upsetting, but instead that the request for antidepressants is endorsed too easily.

Extract 5.

1 I: And when you first kind of made-
2 >you know- said you know< I think I
3 (.) I should go on an antidepressant
4 to that (.) physician u:m how did he
5 respond to that (1) to that >kind of
6 request< or that kind of (.hhh) (.5)
7 um you know your ideas about that?
8 P10: (.hhh) In my↑ (1) experience uh
9 <most family doctor> prescribes
10 antidepressant very easily (.)
11 probably a bit too much: (.5) but
12 uh (1) it's: not considered
13 something (1) ve:ry: (2) seri- uh I
14 mean uh like a very <serious: (.5)
15 decision> it's like okay: you're
16 feeling depressed? I'll give you
17 antidepressant it's almost auto-
18 automatic <in my:>-
19 I: >Right so you didn't encounter
20 any [resistance? or<]
21 P10: [Not at all]
22 I: Any kind of questioning? Or-
23 P10: Not at all.

In this brief account, this interviewee offered quite a different perspective on the experience of asking for and receiving antidepressants from his family physician. Though he constructed an account of having requested antidepressants, this participant created a somewhat contradictory version of himself as uncomfortable with the ease with which his request proceeded and with his physician's apparent lack of involvement in the decision-making process. While his physician was certainly positioned as facilitating this patient's request without inquiry,

discussion, or resistance, this approach was constructed in a negative way rather than in a positive manner that might be expected to be associated with receiving what one requested. For instance, it appears that he was leveling criticism toward his physician when he referenced “too much:” (l. 11) ease with which antidepressants are prescribed, when he argued that this particular treatment decision was generally not considered seriously by physicians, and when he stated that antidepressants were provided too easily and as a routine or “automatic” (ll. 17-18) treatment recommendation whenever people are “feeling depressed” (l. 16). This position is somewhat unexpected, given that this participant requested antidepressants from his physician, who evidently endorsed the request.

The interviewee’s negative portrayal of his physician’s prescribing behaviour is better understood in the context of his account of antidepressants (in other parts of his interview) as a largely ineffective treatment option for his circumstances. Though he did not provide a specific account of how his physician should have responded to his request for antidepressants, he did frame his physician’s ease of prescribing as a lack of involvement and as generally unwelcomed. His response to my two final questions (“not at all”; l. 21; 23), in combination with his previous comments regarding the ease of acquiring antidepressants, suggested that he would have expected or preferred his physician to be more involved in the treatment decision-making process, to be more proactive in clarifying his actual need for antidepressants, and perhaps even to resist or deny his request.

In the final extract I explore an interviewee’s account of requesting and receiving antidepressants and eventually questioning the safety and appropriateness of this particular medication.

Extract 6.

1 P8: Yeah so (.) (.hhh) (.) so: I

2 guess during my hospital stay <1 got
 3 hooked up with: a psychiatrist
 4 again> (.3) and so: because my:-
 5 the psychiatrist that I'd had (.)
 6 pre- previous↑ (.) um: had retired
 7 (.) so I then just didn't really
 8 >have one at all and I kind of let
 9 it< (.hhh) (1) you know I just let
 10 it go: I didn't really kind of (.)
 11 seek out ano[↑]ther one or anything
 12 like that
 13 I: °Things were okay at that time°
 14 P8: Yeah and- and I didn't feel like
 15 I needed (.5) °really one at all° so
 16 (.) um: (.) so then I: (.5) I got
 17 (.5) <hooked up with a new
 18 psychiatrist↓ when- when I was like
 19 during my hospital stay> (1.5) and
 20 uh:: (1.5) so (.5) <and as far as
 21 having a- a: (.3) GP I don't- like
 22 I had[↑] on:e[↑] (.) but I didn't
 23 really- I wasn't really too happy
 24 with her> because I found her to be
 25 really (.) ambivalent[↑] a lot of the
 26 time just not [really]
 27 I: [okay]
 28 P8: that engaged in my care↓ (.hhh)
 29 so I was kind of on the lookout for
 30 (.5) a new GP and so during this
 31 time <I (1) went to (.) um (.) a
 32 clinic-> a community clinic that's
 33 closer to where I live (.5) a:nd I-
 34 I actually[↑] I got a recommendation

35 from a friend of mine um: (.3) who
 36 used to work out of that clinic °as
 37 a- as a physician° (.) and so he sent
 38 me to this doctor (.5) and↓ (.hhh)
 39 <so I guess (.) what ended up
 40 happening> as I look at it from (.)
 41 sort of (.) a perspective of being
 42 >a little bit better< (heh heh)
 43 I: (°yeah the other side°)
 44 P8: is that (.5) yeah as the- as I
 45 started to get sedated and brought
 46 down from my manic (.) episode (.5)
 47 um I started to head into
 48 depression↑ (1) so:: I asked the GP-
 49 like I went in to see this GP and
 50 I asked him if he could put [me on]
 51 I: [The new GP or]?
 52 P8: Yeah the new GP and I asked him
 53 if he could maybe put me on an
 54 antidepressant (1) an:d uh↓: (1) <he
 55 gave me- he prescribed Effexor (1)
 56 which (.) I tried (.) and it made
 57 me> (.) really (.5) like↓ kind of
 58 >almost feeling manic and feeling
 59 lots of anxiety and stuff↑<
 60 I: °And he was aware of kind of your
 61 history and°
 62 P8: mmmm yeah [he was]
 63 I: [(and stuff)]
 64 like that
 65 P8: Yeah and he knew what
 66 medications I was taking and
 67 everything like that >so then I went
 68 to my psychiatrist and he said no

69 you shouldn't be taking Effexor<

70 (heh heh heh)

Like the previous extract, this interviewee's request for antidepressants did not turn out as she might have expected. This participant first alluded to her desired approach to treatment decision-making when she framed her original family physician as not providing the level of involvement or engagement in her treatment that she wished (ll. 24-28), which appears to have generated her hunt to find a new physician and to request antidepressants. Though the new physician was found through a recommendation from a friend (which might be associated with a hopeful or positive outcome) this event was presented as having not worked out very well. This interviewee focused little on how she phrased her request for antidepressants or how the physician responded and instead provided an account of what resulted from that request.

Unlike the previous extract that depicts general talk that is critical of physicians who prescribe antidepressants too easily, this participant did not construct any overt negative judgment about the new physician. Instead, she constructed an account of experiencing significant side effects from the antidepressants that she requested ("kind of >almost feeling manic and feeling lots of anxiety and stuff↑<"; ll. 57-59) and in turn framed her psychiatrist as determining that this medication was inappropriate (ll. 68-69). It is difficult not to consider the interviewee's earlier talk of being disappointed with her original physician who was "really (.) ambivalent↑" and "just not [really]...that engaged" (ll. 25-28) alongside her anecdote about the new physician whose endorsement of her request for antidepressants was framed as resulting in worsening symptoms. In each case, the outcome of her interaction with each physician appears to be constructed as unsatisfying and generally related to a lower level of involvement, discussion, and deliberation about her treatment than she would have preferred.

Discussion

The manner in which patients account for making requests for antidepressants has largely been ignored in the research literature. Instead, research has tended to focus on the result of such actions, such as whether requests for antidepressants are effective (Kravitz et al., 2005; Mintzes et al., 2003) and how patients would respond to physicians who refuse their requests (Bell et al., 1999). The participants interviewed for the present study evidently arrived at the position that antidepressants are warranted for their circumstances, and they provided accounts of requesting (and usually receiving) prescriptions for antidepressants from their physician. The extracts presented in the first section featured requests framed more as presentations of treatment options rather than as frank demands for antidepressants. In these instances the request was constructed as being subtle to the degree that it was typically framed in deference to the family physician's knowledge and opinion (e.g., "what do you think?"). However, these extracts also provide examples of how these participants hold stronger positions about their preferred treatment option than their method of request might suggest. In this sense, these participants engaged in a persuasive approach to requesting antidepressants, or what might be considered a 'soft sell.'

In describing how they requested antidepressants, the interviewees' subtle persuasive approaches were offered alongside their framing of the physician as having been invited to contribute to the decision-making process and indeed as necessary for the decision to be made. This juxtaposition suggests that these participants may be drawing upon a combination of approaches to treatment decision-making. For instance, the interviewees at once framed themselves as quite autonomous in the manner in which they accounted for their treatment of choice and in their persuasive approach to acquiring antidepressants. At the same time, they framed themselves as deferring to their physician's privileged role in the decision-making process and even discounted their own involvement in some instances. Although framing their

approach to requesting antidepressants as at once paternalistic and autonomous might seem incongruous, the interviewees weaved elements of each together in a way that can be broadly considered to be a joint approach to decision-making, and an approach that privileges the physician's role over that of the patient. Considering that primary care has afforded patients more control and a greater ability to participate in treatment than it once did, these accounts of using subtle persuasive approaches to requesting antidepressants while deferring to the physician might reflect an attempt by the patient-interviewees to explore the boundaries of the treatment decision-making process by attempting to get their treatment needs met while still inviting their physician to share responsibility for their requested treatment.

The extracts presented in the second section are each quite different from one another in terms of their content and the outcomes that result from them; however, they share in common a significant discrepancy between each of the interviewee's construction of his or her preferred level of physician involvement and how the interaction turned out. These extracts depict patient interviewees who framed themselves as having requested antidepressants and as dissatisfied with the outcome of these requests. In the examples, the participants' framing of the issue as either an absence of involvement by the physician or an over-involvement points to the same thing – the lack of a sufficiently joint approach to treatment decision-making between patient and physician. Whereas Bell, Wilkes, and Kravitz (1999) concluded that up to half of their participants would be disappointed if their physician refused their request for antidepressants, the dissatisfaction depicted in the extracts in the second section of this study does not appear to be related solely to whether or not the request for antidepressants was endorsed. Instead the disappointment also appears to be related to the discrepancy between the treatment decision-making approach that these patients wanted from their physician and the one they depict as having actually occurred.

The extracts presented in the second section might also be considered alongside the research that suggests patient requests and not clinical need drive prescriptions for antidepressants when the physician engages in little exploration and validation of the patient's concerns (Epstein et al., 2007). One possibility is that physicians might interpret a request for antidepressants at face value and endorse it or deny it easily and without much discussion with their patient. It has been previously argued that physicians are poor at determining their patients' desired level of involvement during general medical examinations (Cox et al, 2007) and the extracts presented in the second section of this study would seem to reinforce this assertion. These accounts suggest that the possibility of poorly matched decision-making approaches is still quite relevant when patients request antidepressants or other clinical services. These accounts also suggest that some patients are likely to hold their physicians (and not themselves) responsible for poorly matched treatment decisions.

Concluding Remarks

The patient request for clinical services is an increasingly common phenomenon in primary care. Patient interviewees provided accounts of their requests for antidepressants that fit within a joint approach to decision-making which privileges the physician's contribution toward the decision. Interviewees who constructed accounts of dissatisfaction with the outcomes of their requests framed their arguments in terms of a discrepancy between a treatment decision-making approach that they expected and the one they actually encountered. These findings provide support for encouraging physicians to explore patients' requests in order to determine the meaning of the request for treatment to the patient. Finding ways to encourage both physicians and patients to contribute to the generation of open dialogue about preferred approaches to treatment decision-making will become increasingly important as the pendulum continues to swing in the direction of increased patient autonomy.

Study Limitations and Directions for Future Research

This research is perhaps limited in its reliance on conversational interviews as the primary data source. An alternative approach of recording conversations between patients and physicians would provide an additional perspective on the approaches patients use to request antidepressants ‘in the moment.’ Despite the logistical challenges, the strength of such an approach is also its drawback as there would be little opportunity to explore how patient participants make sense of their request. A combined approach of analyzing dialogue between patients and physicians that occurs in real time followed by conversational research interviews with patients would likely serve to balance the strengths and drawbacks of each method.

The extracts that depict dissatisfied participant interviewees also bring to mind important questions about blame and responsibility for failed treatment outcomes that were not addressed in the current research. For instance, in the second section of extracts, the patient interviewees’ explanations for the poor outcomes draw on the physician’s role, while their own contributions are conspicuously absent from their talk. This pattern suggests that while the responsibility for making treatment decisions has shifted to include the patient, some patients might still view the risks associated with poor or undesirable treatment outcomes as resting entirely with their physician. How patients take up or reject responsibility for failed treatments they have requested is an important direction for future research.

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Discussion

The research questions that have guided these individual articles and this overall project are as follows: how do physicians account for their decisions to endorse or deny patient requests for antidepressant medication? As well, how do patients account for their requests for antidepressants from their physicians? In the following section, I explore these questions by bridging Studies 1 and 2 in the context of select research that was presented in the general introduction. Finally, I discuss some limitations of this project and offer some suggestions for future research.

Amongst the research participants featured in Studies 1 and 2, patient requests for antidepressants were presented as commonplace and routine. The research literature is mixed with regard to physicians' positions on requests for antidepressants, with some suggesting that requests encroach on physicians' territory (Tentler et al, 2007) and others suggesting that patient requests lead to improvements in the process of the examination (Feldman et al., 2006) and in the relationship between physician and patient (Murray et al., 2003). Interestingly, the physicians interviewed for Study 1 did not offer particularly positive or negative assessments of this practice, and instead seemed to approach it as something that could instead be considered 'a fact of life' in their current practice. One wonders if these physicians would have been less familiar with patient requests or provided more polarizing accounts if they were interviewed 10 or more years ago when these actions were perhaps less common.

The findings of Studies 1 and 2 suggest that both patient and physician interviewees accounted for their requests for antidepressants and their responses to requests for antidepressants in similar ways. Patient and physician interviewees constructed their actions within what can broadly be considered a joint approach to decision-making and more specifically a physician+ joint approach, with both sets of interviewees involved in the process while

privileging the physician's role above that of the patient. To make sense of these results, consideration must be given to the rapid and recent change in the treatment landscape away from a paternalistic approach toward one in favour of increased patient involvement in the process of medical decision-making. Requests for antidepressants (or any other specific treatment) represent a shift in the relationship between physician and patient particularly when compared to how the practice of Western medicine was structured and undertaken as little as 30 or 40 years ago. It is likely that physicians who have been in practice for even a few years have directly experienced the changing expectations of their patients. As such, it is perhaps fitting that the physician interviewees were drawn to a joint approach that privileges their own role above that of their patients.

One possible argument is that physicians are simply undermining any semblance of their patients' autonomy by promoting certain aspects of it while ultimately exerting control over the final treatment decision. However, the physicians' accounts of being generally open to prescribing antidepressants in addition to their talk about patient requests as being an everyday part of their practice leads me to conclude that this is an unlikely interpretation. Instead, I argue that framing the interaction as a type of joint approach within which these physicians has a strong involvement in the treatment decision allows them to carve out a contributory space for themselves within a treatment visit that does not necessarily demand their input. Maintaining a contributory space is of particular relevance for physicians when the consultation involves a request for antidepressants, as this particular action carries with it the potential to reduce the physician's involvement almost completely, to that of a prescription dispenser, unless limits are imposed and the physician's role is more deliberately asserted.

Discourses of patient-directed treatment are certainly available and patients who request antidepressants presumably want their request to be endorsed. As such, it might have been

expected that the patient interviewees who requested antidepressants would account for their requests in a manner more fitting with a patient-directed approach to treatment, or a joint approach to decision-making that involved a privileging of their own role in the process rather than the that of their physicians (e.g., a patient+ joint approach to treatment decision-making). Instead, the patient interviewees weaved accounts of treatment autonomy and deference to their physician together and ultimately constructed an account of what can be considered a physician+ joint approach as it privileges the physicians' role. One possibility is that this action represents evidence of these patients' uneasiness with the extent to which responsibility for the treatment decision has shifted from the physician to include the patient as well. For example, in some instances patient interviewees constructed accounts of being uncertain about the appropriateness of the medication they are requesting. Perhaps these patients did not want to be left wondering how to proceed if their requested treatment option was ineffective. These findings provide evidence that an entirely equal approach to treatment decision-making is not always desired, even by patients who can be considered quite involved in the process of treatment decision-making. Some research suggests that patients do not involve themselves to a significant degree in their treatment for depression (Simon et al., 2006) and the current findings suggest that this lack of significant involvement might also apply in some instances even when patients take the initiative to make a request for antidepressant medication.

In the introduction I explored a range of different approaches to making treatment decisions in primary care, including the paternalistic models of treatment decision-making, joint approaches to treatment decision-making, and patient-directed models of treatment decision-making. Within each of these categories, I explored several constructs that fit within their broader counterparts, including physician+ joint models (a joint approach within which the physician takes the lead), patient+ joint models (a joint approach within which the patient takes

the lead), and others. Though the treatment approach constructed by the patient and physician interviewees can reasonably be framed as a physician+ joint approach, I hesitated in attaching this particular category label to the accounts of my participants in Studies 1 or 2, in recognition that the research literature already suffers from considerable lexical confusion (Makoul et al., 2006; Moumjid et al., 2007). By framing my participants' constructions of their treatment decision-making approaches through the use of the term 'physician+ joint,' I risk stumbling into the rampant lexical perplexity that characterizes this literature through the inclusion of a new term. By using a broader term (i.e., joint decision-making) or an already established term (i.e., shared decision-making), I avoid potentially contributing to the confusion of terminology but risk framing the approaches constructed by my participants in a way that lacks detail and is insufficiently accurate. Ultimately, I have favoured specificity over my trepidations about introducing a new term within an already crowded lexicon. I take heart in my thought that the term physician+ joint approach describes a construction that has not otherwise been presented in the literature and thereby represents a unique contribution. I will leave it to my readers and the research community to determine whether this and other terms I have presented have value in other research studies within this topic area.

Terms that have been previously defined in specific research studies, such as paternalism, shared decision-making, and informed decision-making are frequently presented as the extreme and centre points of an organizing continuum of treatment decision-making approaches (Cribb & Entwistle, 2010; Makoul & Clayman, 2006; Wirtz et al., 2006). By instead organizing this literature around broader groupings of constructs of paternalism, patient-directed approaches, and joint approaches, it was not my intention to promote new labels of categorization. Instead, this framing of the literature came out of my recognition of the great number of terms related to treatment decision-making and the limitations of the typical presentation of the continuum of

treatment decision-making approaches. It is my assertion that the broader organizing terms that I offer are more inclusive than those commonly presented and promote an understanding of the multiple (and perhaps more flexible) approaches to primary care decision-making and better recognize the nuance and disorderliness that characterizes these constructs. Though the use of these broader terms might not be specific enough to be appropriate for research that uses statistical methods to tease out significant differences between defined groups, they might be a useful way to organize and frame treatment approaches in future qualitative studies on this topic.

Terms and categories are useful tools to organize a literature and to efficiently communicate the meaning of a construct. However, knowing that these physician and patient participants enacted physician+ joint approaches offers little in terms of what the interviewees said and how they said it, to which I will now turn. In studies 1 and 2, I showed how patient and physician interviewees treaded carefully through their use of language with regard to how they constructed their requests for antidepressants and in their approach to endorsing or denying these requests, respectively. Patient interviewees accounted for their requests for antidepressants in the form of a treatment suggestion that I characterized as a ‘soft sell’ (as opposed to a direct request or a demand for antidepressants that might instead be characterized as a ‘hard sell’). Furthermore, the patient interviewees’ accounts reflect their position that antidepressants are an appropriate treatment while at the same time these accounts depict deference to the physician’s knowledge and training. Physicians, in their explanations about managing requests for antidepressants, provided a justification and rationale for why antidepressants were not appropriate for a given circumstance. In doing so, the participants seem to have attempted to avoid any depiction of being pushy, coercive, or otherwise overly directive in the treatment process. Within a medical context that has shifted toward an expectation of greater patient involvement in treatment alongside a de-emphasis on paternalistic approaches, it appears that

these physicians and patients are attempting to walk the line between passivity and coercion; non-involvement and over-involvement. Perhaps it is in order to maintain this balance that careful uses of persuasion were enacted.

Long associated with Western medicine and primary care more specifically, persuasion is typically conceptualized as something that physicians enact on passive patients in order to convince them to take up a recommended treatment. Within a paternalistic framework, this notion of persuasion would certainly have been the status quo, though it has come to take up a negative association within current treatment decision-making contexts (consider, for example, the reframing of ‘compliance’ to ‘adherence’ and eventually to ‘concordance;’ Cushing et al., 2007). The pharmaceutical industry is equally brought to mind when considering persuasion in primary care, particularly in reference to direct to consumer pharmaceutical advertisements (DTCPA) that are argued to be biased, and encouraging of inappropriate medication use (Gilbody et al., 2005; Hollon, 2005). Interestingly, when asked about the potential role of DTCPA in patient requests for antidepressants, physicians and patients alike provided accounts during the interviews of being only vaguely aware of these advertisements. DTCPA did not feature prominently in patient interviewees’ talk of making requests for antidepressants or physician interviewees’ accounts of managing patient requests, perhaps owing to its illegality in Canada and the tendency for American pharmaceutical companies to advertise medications that are not readily available north of the border.

With regard to persuasive actions within the joint approach to treatment decision-making that physicians and patients constructed, the concept of mutual persuasion is perhaps a more fitting approach to this topic. The persuasive actions constructed by the physician and patient interviewees were subtle ones, the sort that might be expected to be co-created between two individuals who need something from one another and who ultimately could have this need met

elsewhere. Many social interactions involve attempts to save face, avoidance of coercion, and more subtle attempts to have needs met. Cribb and Entwistle (2011) argued that as a patient - physician relationship becomes more shared, it becomes more open-ended and the individuals involved become less substitutable, akin to a friendship or an affiliation between colleagues. This comparison would seem to have relevance when considering joint approaches to primary care. In many social interactions, as in the case of the physician and patient interviewees, the relationship and its attendant persuasion appear to go both ways.

Burgoon and Dillard (1995) have acknowledged the failure of researchers to explore the reciprocal nature of social influence in interpersonal communication. Despite there being little research to draw upon, it is fair to consider mutual persuasion in primary care not as something that arose out of the push toward increased patient involvement or due to patient requests for clinical services, but instead as something that was always being done in one form or another, despite the differing levels of relative power and authority between patients and physicians. Lazare, Eisenthal, and Wasserman (1975) claimed that it is a basic assumption that the patient has something in mind that she or he wants, and argued that the physician's essential task is to elicit this request. One can imagine how controversial such an approach might have been in a time when paternalism was well entrenched in the medical culture. If, as these authors contend, all conversations between patients and physicians are, in one sense, 'request conversations,' then it stands to reason that all conversations between patients and physicians are conversations involving some degree of persuasion on both sides. The present studies suggest that in some instances patient requests for antidepressants can be understood better as everyday persuasive actions rather than as attempts to manipulate or coerce. Recognizing this reciprocity might provide those physicians who are challenged by patient requests additional ways to consider requests which are perhaps less threatening to their own sense of involvement in the process.

It can certainly be argued that involvement in treatment decision-making today is an ethical and moral imperative for those patients who want it; however, as the patient and physician interviewees show, such approaches do come with their own challenges. For example, the potential for conflict is always present when two or more people come together and attempt to arrive at some sort of agreement or negotiation. This potential for conflict is particularly relevant when the interaction involves a request by one party for something that the other party has the exclusive privilege to grant or deny, as in the case of patient requests for antidepressants. Studies 1 and 2 point to the potential for conflict to develop within the patient - physician relationship when antidepressants are requested and also provide hints about how conflict might be minimized or resolved.

While the physician interviewees reported a general openness to prescribing antidepressants in their accounts, they also detailed some instances in which they would not prescribe, such as when their patient is not depressed, or if their patient's depression appears to be primarily related to circumstantial issues that antidepressants are not likely to influence. It is evident that these instances are difficult to manage for physicians. I framed their accounts as attempts to avoid conflict through a patient-perspective-based explanation (Paterniti et al., 2010). By accounting for their refusal to prescribe antidepressants in a careful, patient-centered manner, these physicians are able to frame themselves as maintaining their necessary gatekeeper role while also maintaining their relationship with the patient. Though it has been argued that up to half of patients will be disappointed if their physician refuses their request for a specific drug and many may go so far as to seek their request elsewhere (Bell et al., 1999), it is evident from their accounts that the physicians in the present study attempted to guard against such possibilities. One particular approach that was constructed involved doing more than simply refusing the (inappropriate) request and instead discussing with the patient why the medication he or she

requested was not ideal. In other words, regardless of whether the patient request is refused or endorsed, the decision is treated as a joint activity between patient and physician. In some instances, this approach was framed as resulting in reduced conflict and maintenance of the relationship between patient and physician.

Ultimately, unless patients disclose their dissatisfaction with their physicians directly, physicians have no real way of knowing just how their patients feel about being refused a request for antidepressants (regardless of whether or not a discussion occurred alongside the refusal), or about the physician's treatment approach in general. In this sense, any conflict that might occur is likely to go unseen or unknown. Evidently, these unknown conflicts happen frequently, as patient attrition is a common occurrence in primary care (Safran, Montgomery, Chang, Murphy, & Rogers, 2001). During one interview section that was not selected for analysis, a physician provided an account of having a patient call to have her file transferred to a nearby practice with no explanation, leaving this physician only to guess that the patient was displeased with some aspect of her care. In Extract 4 from Study 1, the physician acknowledged this possibility when she suggested that patients might simply attend another physician's office to get antidepressants if she cannot convince them that medication will not be helpful. Like consumers taking their business elsewhere, such an action can represent a rift between physician and patient that the physician interviewees framed themselves as obviously attempting to avoid.

These rifts were explored more directly in Study 2, and particularly when patient interviewees constructed explanations for the unexpected outcomes that resulted from their requests for antidepressants. Here they accounted for these outcomes by framing their physicians as under- or overinvolved in the treatment decision compared to their expectation of a more jointly arrived at approach. Indeed, some research does support that physicians tend to misunderstand what they perceive to be most patients' desired approaches to treatment decision-

making (Cox et al., 2007). The extracts featured in Study 2 point to a risk that physicians might read a request for antidepressants as the patient's desire for a more autonomous approach to decision-making than the physician him- or herself is comfortable with or than the patient actually wants. There is no indication from these accounts that the patient interviewees raised their concerns with their physicians or otherwise attempted to resolve the issue directly, but instead appear to have simply let it go or to have sought services elsewhere.

One wonders if more open communication and a straightforward discussion about the patient's request and his or her desired approach to treatment decision-making might have changed the result of these conversations. Of course, conflict is unavoidable within the patient - physician dynamic and might be likely to occur more frequently as patients become more experienced and comfortable with a more equitable relationship than was historically available between themselves and their physicians. Whether this conflict is likely to occur outside the examination room in a more indirect fashion or in the form of a conversation inside the examination room remains an open question. The degree to which physicians are able to respond directly to these requests, and communicate openly with their patients about their treatment of choice as well as their desired approach to physician involvement might influence the extent to which conflicts are able to be avoided or minimized.

Depression Treatment in Primary Care

Depression is a contentious topic with an abundance of available discourses that are widely taken up to explain and account for this construct, including depression as a socio-economic matter, an internal conflict, and an identity, among others. One discourse stands out as being the most prominent in modern western societies: depression as biomedical dysfunction. Similarly, amongst a range of approaches and treatments, antidepressant medications are an exceedingly common treatment for depression (Pratt et al., 2011) and are argued to work by

altering levels of neurotransmitters in the brain, such as serotonin and norepinephrine (France et al., 2007). The biomedical explanation of depression applies equally to antidepressant treatment and serves to strengthen and sustain the discourses that construct such medication. Of course, antidepressant medication as the default treatment for depression belies the range of different ways of understanding depression that are taken up, and in some ways suggests that a biomedical understanding of depression is something that is uncontested and can be considered ‘fact.’

Antidepressants as the de facto treatment for depression also appears to be in significant conflict with accumulating arguments about the ineffectiveness of antidepressants in all but the most severe cases of depression, (Fournier et al., 2010; Kirsch et al., 2008; Middleton et al., 2011), with concerns about adverse side effects (Ables et al., 2010; Ferguson, 2001), and with significant discontinuation rates (Monfared et al., 2006). While there are certainly arguments to be made that second-generation antidepressants are far superior to the first-generation antidepressants that were created before them, there is much contention surrounding modern antidepressant treatment. Interestingly, this contentiousness was not part of the talk generated by physician interviewees. Some of the physician participants did provide accounts of antidepressants as inappropriate in specific circumstances (for example, when it appeared that the patient was not depressed, or when difficult social circumstances appeared to account for their symptoms), but none of them suggested that the appropriateness of antidepressants should perhaps be questioned or reconsidered for most or all patients diagnosed with mild to moderate depression, regardless of whether such medication is requested or not.

The absence of such accounts might be explained, in part, by the enduring aphorism that antidepressants ‘won’t do any harm and might do some good’ (Middleton et al., 2011). This persistent notion speaks to the strength of the biomedical discourse surrounding depression, its causes, and its treatment. The conflict between this persisting notion and the research findings

that suggest otherwise raises important questions: if antidepressants are considered the standard treatment for depression amongst physicians (McPherson et al., 2012), and if the appropriateness of using antidepressant to treat depression is increasingly questioned, where does this leave physicians in their management of depression with patients in primary care, and particularly with those patients who request antidepressants? They are certainly in an unenviable position. These issues raise questions about how physicians explain the evidence for and against antidepressants to their patients and to themselves. Of course, treatment options that do not include antidepressants are available within the current framework of primary care, including watchful waiting, psychosocial interventions (such as supportive therapy or cognitive behavioural therapy), and referrals to alternative services. That said, a shift in treatment focus away from antidepressants toward non-pharmaceutical treatments does not necessarily decrease reliance on a problematic biomedical explanation.

I acknowledge that questioning the prevailing biomedical discourse of depression does little to suggest how physicians might respond to patients who seek their help for depression. Middleton and Moncrieff (2011) argued that one significant implication of a reduced reliance on a biomedical discourse of depression is that any felt duty to prescribe antidepressants that physicians might have invariably diminishes. Physicians might find that this diminution of duty to prescribe allows for more room to explore the patient's understanding of his or her symptoms, and to approach depression flexibly as something to understand and work through (or even just sit with) rather than as a distinct illness entity that necessitates a particular, and often ineffective, pharmaceutical intervention. Bryant et al. (2007) similarly remind us in their study exploring the lure of patient choice that offering a choice of treatment is less important than active involvement in the decision-making process itself. Though they were referring to patients, this maxim is equally applicable to physicians. However, with that in mind it should be recognized

that in some instances patients might strongly take up a biomedical explanation for depression and see antidepressants as the only logical treatment. This position might present a challenge to a physician who favoured non-pharmaceutical treatment options for depression or who recused him or herself from any obligation to prescribe antidepressants. Interestingly, none of the patient interviewees framed themselves as insistent on antidepressants as the only treatment that they would consider. Instead, they positioned themselves as open to different and overlapping approaches to making sense of their depression, and requests for antidepressants were presented as one possible treatment option. This suggests that at least some patients might prefer that their physician flexibly explore their concerns rather than defaulting to a prescription for antidepressants, even in instances when antidepressants were requested.

The present research, though specific in its scope of exploring patient requests for antidepressants and physician responses to these requests, raises broader questions about the role of the general practitioner in primary care in the management of depression. Dowrick (2009), for instance, argued that the physician's role lies somewhere between witness to patient suffering and healer. He further distilled the obligations of family physicians down to two basic elements: to acknowledge patient suffering and to offer hope. These notions sit with some dissimilitude alongside Toon's (1999 as cited in Murray et al., 2006) depiction of the primary care physician as a person who can manage patient concerns using a biomechanical approach to medicine. Each of these depictions of what it means to be a physician contributes to the unique role and multiplicity of responsibilities that physicians take up. These depictions also have the potential to contribute toward challenges that physicians face in primary care, as the physician's role as witness to suffering might come up against an expectation of a biomedical approach to addressing the patient's problem.

Perhaps there is some merit in recalling Western medicine's philosophical roots when considering what can be offered to patients who present as depressed i.e., that there is much to be said for the physician's role in witnessing suffering and offering hope. Indeed, the challenges described as arising in the treatment of depression in primary care appear to underscore the importance of those most indispensable and basic of physician skills: open communication, active listening, empathy, and a flexible approach to problem solving. It is possible that in time the controversies associated with second-generation antidepressants will result in their reduction in popularity in much the same way as with first-generation antidepressants, and those that identify themselves as depressed will seek help in settings other than their physician's office. Until then, a focus on core skills may be a useful way for physicians to manage patient requests for antidepressants or other treatments.

Project Limitations and Directions for Future Research

When considering the ways in which patient and physician interviewees constructed their accounts, the context of the research interview method must be acknowledged. This work could be critiqued on the grounds that actual conversations between patients and physicians would have allowed a more direct analysis of how physicians and patients framed their requests for antidepressants and responses to requests with one another. In my reliance on interviews as my method of data generation, this approach could be further critiqued as not necessarily representing 'accurate' accounts compared to what the participants might have actually uttered in their conversations with their physicians or patients. On this point, I have made no claims about the 'truthfulness' of the interviewees' accounts, and instead I have endeavored to craft my arguments from a position that recognizes that these conversations (like all conversations) are limited to the social context within which they were generated. As well I have attempted to avoid language which might suggest that physicians' and patients' talk reflects some 'reality' that

occurred in the examination room. Indeed, my aim was to co-construct and analyze conversations with patients and physicians and encourage reflection on patient requests for antidepressants and their interactions with one another in primary care.

Certainly an analysis of real-time conversations between patients and physicians would be interesting and would allow claims to be made about how patients and physicians frame requests and responses to requests for antidepressants at specific points in conversation in primary care. The benefits of such an approach, of course, must be considered alongside the drawbacks. For instance, it must be acknowledged that recorded ‘in situ’ interviews between patients and physicians would still be influenced by the process of informed consent, and the digital recording device (or the observing researcher). As well, it could not be reasonably expected that abstracted, ‘second order’ varieties of talk would result from observance of real time conversations between physicians and patients in the same way that they would from conversational interviews with researchers. Finally, the logistical challenge of coordinating meetings between actual depressed patients and physicians might be more than can be reasonably expected within a project of this scope.

However, it is important to acknowledge the social context within which these conversations did occur, in particular, that study participants were interviewed by either a Ph.D. level clinical psychologist (and academic researcher) and/or a graduate student in clinical psychology. Since psychologists are known to treat mental health issues using talk therapies and are not licensed to prescribe medications, participants might have contributed versions of their accounts that were less favourable to antidepressants and more favourable to alternative forms of therapy. As well, physician interviewees might have felt compelled to minimize their antidepressant prescribing practices (in favour of other treatments) or to depict greater involvement in treatment decision-making in response to patient requests for antidepressants

than they would in speaking with an interviewer who was, for example, a fellow physician.

While we tried to minimize bias through the wording of our interview questions (Appendices C; H) and by providing our participants with room to take the conversation in the direction that suited them, the context of our interviews inevitably shaped our data.

Of course, the role of the participants themselves must not be discounted or dismissed in their shaping of their accounts. For instance, as presented in Study 1, physicians who responded to the recruitment advertisements likely have an interest in the treatment of depression that goes beyond antidepressants and, indeed, many physicians openly acknowledged a special interest in this topic area. The same is true of patient interviewees. Thus, while a co-construction between individuals with a special interest in depression and antidepressants might be more likely to lead to certain types of conversations, and less likely to lead to certain other types of conversations, this need not be considered a particular research weakness. In one sense it might be considered a strength of this particular research as both interviewers and interviewees have interest and experience with the topic at hand. That said, one can still acknowledge (as I do in the Study Limitations and Directions for Future Research section of Study 1) the merit in interviewing participants with different experiences and backgrounds, such as physicians without a special interest in depression.

With regard to future research, I return to the notion that approaches to decision-making have changed considerably over the past 30 to 40 years. As such, important topics related to joint decision-making, such as reciprocal persuasion between patients and physicians and conflict in joint decision-making, are very much deserving of further research. In the context of my critique of the biomedical explanatory discourse of depression, future research might be directed toward physicians who, as a rule, do not prescribe antidepressants. It would be fruitful to examine approaches to denying requests used by these physicians. For instance, do such physicians rely

on providing information about the controversies surrounding depression use or instead use a strategy of outright refusal? I would also be curious to ask physicians who do not typically prescribe antidepressants about the treatment options they do offer and about the explanatory frameworks they use in talking about depression with their patients. Likewise, conversations with patients whose depression is managed in primary care without antidepressants could be revealing, as might conversations with patients who manage their depression entirely outside of a (Western) medical approach to primary care. The current literature on depression treatment within primary care is largely focused on antidepressants, and understandably so given their widespread use and acceptance. It is hoped that future research focusing on ways of conceptualizing and treating depression will recognize, but ultimately go beyond, the problematic biomedical discourse.

Concluding Remarks

Physicians in primary care face incredible challenges: the variety of role expectations, the range of undifferentiated complaints and symptoms that patients present, the complexity and variety of modern medical treatments, and a changing approach to treatment that encourages increased patient involvement. As a “first port of call” (Murray et al., 2006, p. 206), primary care is a logical destination for people who present with a range of issues, including depression. Patient requests for antidepressants and other clinical services in primary care are common and might be expected to increase as patients become more comfortable with available opportunities to be involved in treatment decision-making.

The patient and physician interviewees provided accounts of enacting a physician+ joint approach to making and managing requests for antidepressants. This approach can be considered a joint approach that involves both the patient and the physician in the process of making the treatment decision and in making the treatment decision itself, but it ultimately privileged the

physician's role over that of the patients. Through acts of mutual persuasion, physician and patient interviewees provided accounts in which they try to get their respective needs met, while attempting to avoid presenting themselves as coercive or uninvolved. However, antidepressants are not likely to be an appropriate treatment option for all who request them, and this research suggests that conflict may be avoided in some instances when physicians involve their patients in this decision and explain their rationale for not prescribing. Whether or not patient requests are appropriate or can be endorsed, requests are a cue for physicians to listen carefully to what their patient is telling them about their depression, its cause, and its potential treatment.

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Appendix A

(Date)

(Physician's name and address)

Dear Dr. (Name of physician):

I am writing to invite you to participate in a program of research investigating how physicians make decisions to diagnose and treat patients for depression, and how patients who are diagnosed as depressed understand the diagnostic and treatment practices of their physicians.

Your involvement in the project would include participating in an individual interview with us, followed later by participation in a focus group with fellow physicians. Please refer to the **blue sheet** enclosed for more details.

While much research has been directed toward understanding the patient perspective, there has been comparatively little attention directed toward making sense of the challenges physicians face in making diagnostic and treatment decisions for depression.

This research has the potential to inform both physicians and lay persons about the different (and sometimes conflicting) knowledge and experiences that are brought to bear in diagnostic and treatment decisions for depression, and may result in suggestions for how to improve the quality of care for depression.

You will be paid an honorarium of \$300.00 (total) for your participation in the interview and the focus group.

Our project is funded by the **Social Sciences and Humanities Research Council of Canada** and is approved by the Behavioural Research Ethics Board of the University of Saskatchewan. For information about ethics board approval, please call the Ethics Unit at the University of Saskatchewan (966-2084).

There are 3 ways to contact us in order to get more information or become involved:

1. call us at 966-6666
2. email linda.mcmullen@usask.ca or jeff.letourneau@usask.ca
3. fill in and fax the **pink sheet** to 966-6630

We look forward to speaking with you in the coming weeks to ensure that you received this package of materials.

Sincerely,

Linda McMullen, Ph.D
Principal Investigator
Professor of Psychology

Jeff Letourneau, B.A. (Hons.)
Project Manager
Doctoral Student in Clinical Psychology

Appendix B

Consent Form (Physician Interviewees)

You are invited to participate in a study entitled **Patient and Physician Accounts of Antidepressant Requests in Primary Care**

Researcher(s): Dr. Linda McMullen, Department of Psychology, University of Saskatchewan, 306 966 6666, linda.mcmullen@usask.ca

Purpose and Procedure: The objective of this research is to investigate how family physicians and lay persons construct and account for their diagnostic and treatment practices for depression, and how knowledge of these practices can inform the notion of concordance, i.e., the view that treatment decisions are a partnership between patients and health-care professionals. This study consists of two parts. In part 1, you are invited to participate in a 1 – 1 ½ hour individual interview pertaining to the diagnostic and treatment practices associated with depression. This interview will be observed by research staff from behind privacy glass. In part 2, you will be invited back to discuss this topic in further detail with other physicians in a 1 - 2-hour focus group. For the focus group discussion, you will be given a summary of the analysis of the individual interviews with physicians and with lay persons, and will be asked to consider the implications of this analysis for physician-patient relationships. After completion of the project, you will be given a summary of the findings and recommendations upon request. The results of the research will be presented in traditional academic settings (e.g., at conferences, colloquia) and will be submitted for publication in peer-reviewed academic journals. In addition, they may be presented in a book for a lay audience, and will form the basis for talks to local health professionals and to the general public, and for short newspaper articles. Data will be reported as direct quotations with all identifying information removed.

Potential Benefits: Benefits of this research include the potential to inform lay persons and health-care professionals about the different (and sometimes conflicting) knowledge and experiences that are brought to bear in diagnostic and treatment decisions for depression, and to contribute to an understanding of ways in which professionals and lay persons might work together more productively. As such, it holds the promise of leading to recommendations for improving the quality of care for depression. **There is, however, no guarantee that you will personally benefit from your involvement.**

Potential Risks: There is no anticipated risk or deception in this study. Participants will be aware of the purpose and why they are participating and may choose not to participate or respond without penalty.

Storage of Data: During the study, all data (audio recordings and transcripts) will be securely stored with the researcher in the Department of Psychology. Dr. Linda McMullen will ensure that data are stored in a secure location for a minimum of five years after the completion of the study. When the data are no longer required, they will be destroyed.

Confidentiality: Measures will be taken to ensure the confidentiality of all participants. Data will be reported in the form of quotations, and all identifying information will be removed from

the transcripts. Pseudonyms will be used in the place of real names. With respect to the focus group interviews, participants will be other family physicians who have volunteered to participate in individual interviews. In the case of these groups, anonymity will be absent, and there are limits to which the researcher can ensure the confidentiality of the information shared. You will be asked to sign a confidentiality clause acknowledging your responsibility and agreement to protect the identity of the other participants as well as the integrity and confidentiality of what others in the group have said during the research sessions.

Right to Withdraw: Your participation is voluntary, and you can answer only those questions that you are comfortable with. **You may request that the recording device be turned off at any time.** The information that is shared will be held in strict confidence by members of the research team. You may withdraw from the study for any reason, at any time, without penalty of any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed at your request. The researcher will advise you of any new information that could influence your decision to participate in the ongoing parts of the study.

Compensation: You will be paid an honorarium of \$300.00 (total) for your participation in the individual interview and the focus group. Should you withdraw from the study before completing both parts (interview and focus group), you will receive a pro-rated amount.

Questions: If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researcher at the number and email address provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on 19 September 2007. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out-of-town participants may call collect.

Follow-Up or Debriefing: Once the study is complete, a summary of the results will be available to participants upon request.

Consent to Participate: I have read and understood the description provided; I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project, understanding that I may withdraw my consent at any time. A copy of this Consent Form has been given to me for my records.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

Appendix C

Interview Questions (Physician Interviewees)

Describe the nature of your family practice.

Describe how you go about determining if one of your patients is depressed.

- Do you use a screening device?
- Do you rely on DSM-IV criteria?
- Do you use a list of necessary and sufficient criteria?

Describe how you determine whether, and how, to treat a patient for depression.

For what reasons, or under what circumstances, do you prescribe antidepressants?

What do you do when one of your patients to whom you have prescribed antidepressants stops taking them before recommended?

Do you ever feel the need to motivate your patients to take antidepressants? If so, what do you do?

Do you recommend treatments other than antidepressants for depression? If so, what do you recommend and under what circumstances?

Has the nature of your diagnostic and treatment practices for depression changed over the time you have been in practice?

Do you experience any dilemmas in your diagnostic and treatment practices for depression (e.g., believing that antidepressants are the treatment of choice for a particular patient, but wanting to support that patient's decision not to take antidepressants)?

Have you ever felt that patients were requesting a prescription for antidepressant medication from you? If so, what does this look like? (e.g., was it subtle? more direct?)

How do you approach these situations?

What are the factors that you see as possibly influencing patients to make such requests?

Do you find the number of patients making such requests has changed over the time you have been in practice?

Are there circumstances that lead you to prescribe antidepressants (or not to prescribe) which you later questioned? If so, how do you make sense of this?

Have your diagnostic or treatment practices ever been affected by patient requests for antidepressants? How so?

What is your sense of potential implications of such requests? (e.g., on the relationship, on prescribing rates, on patients' understanding of depression, on your understanding of depression?)

In your view, is depression under-treated, over-treated, or appropriately treated at the population level?

Appendix D

Transcript Release

Patient and Physician Accounts of Antidepressant Requests in Primary Care

I, _____ (please print name), have reviewed the transcript of my personal interview from the above entitled study, and have been provided the opportunity to add, alter, and delete information from the transcript. I acknowledge that the transcript reflects what I said in my personal interview with Linda McMullen and Jeff Letourneau. I hereby authorize the release of this transcript to Linda McMullen and Jeff Letourneau to be used in the manner described in the consent form. If this is true, please sign and date below and fax to **966-6630**.

Participant

Date

Researcher

Date

Appendix E

Jefferson (1984) Transcript Notation

Symbol	Use
[text]	Indicates the start and end points of overlapping speech
(# of seconds)	A number in parenthesis indicates the time, in seconds, of a pause in speech
(.)	A brief pause, usually less than .2 seconds
↓	Indicates falling pitch or intonation
↑	Indicates rising pitch or intonation
-	Indicates an abrupt halt or interruption in utterance
>text<	Indicates that the enclosed speech was delivered more rapidly than usual for the speaker
<text>	Indicates that the enclosed speech was delivered more slowly than usual for the speaker
°text°	Indicates whisper, reduced volume, or quiet speech
underline	Indicates the speaker is emphasizing or stressing the speech
:::	Indicates prolongation of sound
(hhh)	Audible exhalation
(.hhh)	Audible inhalation
(text)	Speech which is unclear or in doubt in the transcript
((<i>italic text</i>))	Annotation of non-verbal activity

Appendix F

Have you requested antidepressants from your physician?

We want to talk to individuals who have requested antidepressants from a physician, whether or not you ended up receiving them. Your involvement will consist of participating in 1 hour, audio-recorded individual interview.

To find out more about this study, please contact Jeff Letourneau
(Doctoral Student in Clinical Psychology, University of Saskatchewan) at

881-0438 or jeff.letourneau@usask.ca

This study has been approved by the Behavioural Research Ethics Board of the University of Saskatchewan.

881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438 jjl844@mail.usask.ca	Depression study 881-0438
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Appendix G

Consent Form (Patient Interviewees)

You are invited to participate in a study entitled **Patient and Physician Accounts of Antidepressant Requests in Primary Care**

Researcher(s): Jeff Letourneau, B.A. (Hons.) Department of Psychology, University of Saskatchewan, 306 717 0438, jeff.letourneau@usask.ca

Purpose and Procedure: The objective of this research is to investigate how lay persons and physicians construct and account for their diagnostic and treatment practices for depression, and how knowledge of these practices can inform the notion of concordance, i.e., the view that treatment decisions are a partnership between patients and health-care professionals. You are invited to participate in a 1 – 1 ½ hour individual interview pertaining to the diagnostic and treatment practices associated with depression and requests for antidepressant medication. This interview will be audiotaped. The results of the research will be presented in traditional academic settings (e.g., at conferences, colloquia) and will be submitted for publication in peer-reviewed academic journals. In addition, they may be presented in a book for a lay audience, and will form the basis for talks to local health professionals and to the general public, and for short newspaper articles. Data will be reported as direct quotations with all identifying information removed.

Potential Benefits: Benefits of this research include the potential to inform lay persons and health-care professionals about the different (and sometimes conflicting) knowledge and experiences that are brought to bear in diagnostic and treatment decisions for depression, and to contribute to an understanding of ways in which professionals and lay persons might work together more productively. As such, it holds the promise of leading to recommendations for improving the quality of care for depression. **There is, however, no guarantee that you will personally benefit from your involvement.**

Potential Risks: There is no anticipated risk or deception in this study. Participants will be aware of the purpose and why they are participating and may choose not to participate or respond without penalty.

Storage of Data: During the study, all data (audio recordings and transcripts) will be securely stored with the researcher in the Department of Psychology. My supervisor, Dr. Linda McMullen will ensure that data are stored in a secure location for a minimum of five years after the completion of the study. When the data are no longer required, they will be destroyed.

Confidentiality: Measures will be taken to ensure the confidentiality of all participants. Data will be reported in the form of quotations, and all identifying information will be removed from the transcripts. Pseudonyms will be used in the place of real names.

Right to Withdraw: Your participation is voluntary, and you can answer only those questions that you are comfortable with. **You may request that the recording device be turned off at any time.** The information that is shared will be held in strict confidence by members of the research team. You may withdraw from the study for any reason, at any time, without penalty of

any sort. If you withdraw from the study at any time, any data that you have contributed will be destroyed at your request. The researcher will advise you of any new information that could influence your decision to participate in the ongoing parts of the study.

Questions: If you have any questions concerning the study, please feel free to ask at any point; you are also free to contact the researcher at the number and email address provided above if you have questions at a later time. This study has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on 19 September 2007. Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (966-2084). Out-of-town participants may call collect.

Follow-Up or Debriefing: Once the study is complete, a summary of the results will be available to participants upon request.

Consent to Participate: I have read and understood the description provided; I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project, understanding that I may withdraw my consent at any time. A copy of this Consent Form has been given to me for my records.

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

Appendix H

Interview Questions (Patient Interviewees)

Describe how you came to see a family physician for depression.

- How did you decide that you might be depressed?
- How did you decide to seek advice from your family physician?

Did the physician make a diagnosis of depression? What did you think of this?

Did you go to the physician with a specific goal of being prescribed antidepressants? If so, how did you arrive at this goal?

How did you go about achieving this goal?

- How did the physician respond?
- Were you successful?

How would you describe your experience with antidepressant drugs?

- Did you take them as prescribed?
- Did you discontinue your medication without the consent of your doctor?

What did you think of the way(s) in which you were treated for depression? Has this changed over time?

From what sources have you gotten information about depression and antidepressants (e.g., magazines, television ads, internet, friends, family, physicians)?

Compared to the average person, how knowledgeable would you say you are about depression and antidepressant medication?

Have you ever treated yourself for depression without consulting a physician? If so, what have you done?

Have you ever decided not to seek treatment for depression? How did you come to this decision and what were the outcomes?

How would you describe your relationship/role with your family physician with respect to being diagnosed and/or treated for depression?

In your opinion, is depression under-treated, over-treated, or appropriately treated in the general population?